



AMA House of Delegates Handbook

2023 Annual Meeting
Hyatt Regency Chicago / June 9-14

Access the handbook online at ama-assn.org/hod-business.

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.
- No action has been taken on anything herein contained, and it is informational only.
- Only those items that have been acted on finally by the House can be considered official.
- **REMINDER:** *Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.*



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with “abortion” and running to “women”; the former topic was assigned the number 5, and “women” was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- “H” – for statements that one would consider positional or philosophical on an issue
- “D” – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- “G” – for statements related to AMA governance
- “E” – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available [online](#) as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

- BOT – Board of Trustees
- CCB – Council on Constitution and Bylaws
- CEJA – Council on Ethical and Judicial Affairs
- CLRPD – Council on Long Range Planning and Development
- CME – Council on Medical Education
- CMS – Council on Medical Service
- CSAPH – Council on Science and Public Health

If a resolution was involved, “Res” is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (A-23)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, June 10, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

- 1. Memorandum from the Speaker**
- 2. Understanding the Recording of American Medical Association Policy**
- 3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**
- 4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities**
- 5. Seating Allocation and Seating Chart for the House of Delegates**
- 6. Hotel Maps**
- 7. Official Call to the Officers and Members of the AMA**
 - Officials of the Association and AMA Councils**
 - Ex Officio Members of the HOD**
 - SSS Representatives**
 - Listing of Delegates and Alternate Delegates**
- 8. Reference Committee schedule and room assignments**
- 9. Note on Order of Business**
- 10. Summary of Fiscal Notes**
- 11. List of resolutions by sponsor**

FOLLOWING COLLATED BY REFERRAL

- 12. Report(s) of the Board of Trustees - Sandra Adamson Fryofer, MD, Chair**
 - 01 Annual Report (F)
 - 02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
 - 03 2022 Grants and Donations (Info. Report)
 - 04 AMA 2024 Dues (F)
 - 05 Update on Corporate Relationships (Info. Report)
 - 06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 07 AMA Performance, Activities, and Status in 2022 (Info. Report)
 - 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023 (Info. Report)
 - 09 Council on Legislation Sunset Review of 2013 House Policies (B)

- 10 American Medical Association Health Equity Annual Report (Info. Report)
 - 11 HPSA and MUA Designation For SNFs (B)
 - 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners (B)
 - 13 Delegate Apportionment and Pending Members (F)
 - 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations (G)
 - 15 National Cancer Research Patient Identifier (Amendments to C&B)
 - 16 Informal Inter-Member Mentoring (Info. Report)
 - 17 AMA Public Health Strategy (D)
 - 18 Making AMA Meetings Accessible (F)
 - 19 Medical Community Voting in Federal and State Elections (Info. Report)
 - 20 Surveillance Management System for Organized Medicine Policies and Reports (F)
- 13. Report(s) of the Council on Constitution and Bylaws - Kevin C. Reilly, Sr., MD, Chair**
- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update (Amendments to C&B)
- 14. Report(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions (Amendments to C&B)
 - 02 Ethical Principles for Physicians In Private Equity Owned Practices (Amendments to C&B)
 - 03 Short-term Medical Service Trips (Amendments to C&B)
 - 04 Responsibilities to Promote Equitable Care (Amendments to C&B)
 - 05 CEJA's Sunset Review of 2013 House Policies (Amendments to C&B)
 - 06 Use of De-identified Patient Information D-315.969 (Info. Report)
 - 07 Use of Social Media for Product Promotion and Compensation (Info. Report)
 - 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report (Info. Report)
- 15. Opinion(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
- 01 Amendment to Opinion 4.2.7, "Abortion" (Info. Report)
 - 02 Amendment to Opinion E-10.8, "Collaborative Care" (Info. Report)
 - 03 Pandemic Ethics and the Duty of Care (Info. Report)
- 16. Report(s) of the Council on Long Range Planning and Development - Edmond B. Cabbabe, MD, Chair**
- 01 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)
 - 02 A Primer on the Medical Supply Chain (Info. Report)
- 17. Report(s) of the Council on Medical Education - John P. Williams, MD, Chair**
- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies (C)
 - 02 Financing Medical Education (C)
 - 03 Financial Burdens and Exam Fees for International Medical Graduates (C)
 - 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (C)
 - 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)
 - 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants (C)
 - 07 Management and Leadership Training in Medical Education (C)
 - 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (C)
 - 09 The Impact of Midlevel Providers on Medical Education (C)
- 18. Report(s) of the Council on Medical Service - Lynn L. C. Jeffers, MD, Chair**
- 01 Council on Medical Service Sunset Review of 2013 House Policies (G)

- 02 Medicare Coverage of Dental, Vision, and Hearing Services (A)
- 03 Private Insurer Payment Integrity (A)
- 04 Bundled Payments and Medically Necessary Care (A)
- 05 Prescription Drug Dispensing Policies (G)
- 06 Health Care Marketplace Plan Selection (Info. Report)
- 07 Reporting Multiple Services Performed During a Single Patient Encounter (A)
- 08 Impact of Integration and Consolidation on Patients and Physicians (G)
- 09 Federally Qualified Health Centers and Rural Health Care (G)

19. Report(s) of the Council on Science and Public Health - Noel N. Deep, MD, Chair

- 01 Oppose Scheduling of Gabapentin (E)
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices (E)
- 03 Regulation and Control of Self-Service Labs (E)
- 04 School Resource Officer Violence De-Escalation Training and Certification (D)
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers (D)
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections (D)
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders (D)
- 08 Sunset Review of 2013 HOD Policies (D)

20. Report(s) of the HOD Committee on Compensation of the Officers - Ray C. Hsiao, MD, Chair

- 01 Report of the HOD Committee on the Compensation of the Officers (F)

21. Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies (F)

22. Resolutions

- 001 Opposing Mandated Reporting of LGBTQ+ Status (Amendments to C&B)
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports (Amendments to C&B)
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation (Amendments to C&B)
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research" (Amendments to C&B)
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees (Amendments to C&B)
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare (Amendments to C&B)
- 007 Independent Medical Evaluation (Amendments to C&B)
- 101 Updating Physician Job Description for Disability Insurance (A)
- 102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use (A)
- 103 Movement Away from Employer-Sponsored Health Insurance (A)
- 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment (A)
- 105 Studying Population-Based Payment Policy Disparities (A)
- 106 Billing for Traditional Healing Services (A)
- 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use (A)
- 108 Sustainable Reimbursement for Community Practices (A)

- 109 Improved Access to Care For Patients in Custody of Protective Services (A)
- 110 Long-Term Care Coverage for Dementia Patients (A)
- 201 Pharmacists Prescribing for Urinary Tract Infections (B)
- 202 Support for Mental Health Courts (B)
- 203 Drug Policy Reform (B)
- 204 Supporting Harm Reduction (B)
- 205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness (B)
- 206 Tribal Public Health Authority (B)
- 207 Ground Ambulance Services and Surprise Billing (B)
- 208 Medicaid Managed Care for Indian Health Care Providers (B)
- 209 Purchased and Referred Care Expansion (B)
- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border (B)
- 211 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits (B)
- 212 Marijuana Product Safety (B)
- 213 Telemedicine Services and Health Equity (B)
- 214 Advocacy and Action for a Sustainable Medical Care System (B)
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud (B)
- 216 Improved Foster Care Services for Children (B)
- 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools (B)
- 218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners (B)
- 219 Repealing the Ban on Physician-Owned Hospitals (B)
- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations (B)
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool (B)
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA) (B)
- 223 Protecting Access to Gender Affirming Care (B)
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers (B)
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (C)
- 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations (C)
- 303 Medical School Management of Unmatched Medical Students (C)
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement (C)
- 305 Indian Health Service Graduate Medical Education (C)
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students (C)
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents (C)
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants (C)
- 309 Against Legacy Preferences as a Factor in Medical School Admissions (C)
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation (C)

- 311 Residency Application Support for Students of Low-Income Backgrounds (C)
- 312 Indian Health Service Licensing Exemptions (C)
- 313 Filtering International Medical Graduates During Residency or Fellowship Applications (C)
- 314 Support for International Medical Graduates from Turkey (C)
- 401 Metered Dose Inhalers and Greenhouse Gas Emissions (D)
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance (D)
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (D)
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers (D)
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court (D)
- 406 Increase Employment Services Funding for People with Disabilities (D)
- 407 Addressing Inequity in Onsite Wastewater Treatment (D)
- 408 School-to-Prison Pipeline (D)
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training (D)
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs (D)
- 411 Protecting Workers During Catastrophes (D)
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal (D)
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave (D)
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population (D)
- 415 Environmental Health Equity in Federally Subsidized Housing (D)
- 416 New Policies to Respond to the Gun Violence Public Health Crisis (D)
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health (D)
- 418 Increasing the Availability of Automated External Defibrillators (D)
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System (D)
- 420 Foster Health Care (D)
- 421 Prescribing Guided Physical Activity for Depression and Anxiety (D)
- 422 National Emergency for Children (D)
- 423 Reducing Sodium Intake to Improve Public Health (D)
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home (D)
- 501 AMA Study of Chemical Castration in Incarceration (E)
- 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures (E)
- 503 Increasing Diversity in Stem Cell Biobanks and Disease Models (E)
- 504 Regulating Misleading AI Generated Advice to Patients (E)
- 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations (E)
- 506 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development (E)
- 507 Recognizing the Burden of Rare Disease (E)
- 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses (E)
- 509 Addressing Medical Misinformation Online (E)
- 510 Comparative Effectiveness Research (E)
- 511 Regulation of Phthalates in Adult Personal Sexual Products (E)

- 512 Wheelchairs on Airplanes (E)
- 513 Substance Use History is Medical History (E)
- 514 Adolescent Hallucinogen-Assisted Therapy Policy (E)
- 515 Regulate Kratom and Ban Over-The-Counter Sales (E)
- 516 Fasting is Not Required for Lipid Analysis (E)
- 601 Solicitation using the AMA Brand (F)
- 602 Supporting the Use of Gender-Neutral Language (F)
- 603 Environmental Sustainability of AMA National Meetings (F)
- 604 Speakers Task Force to Review and Modernize the Resolution Process (F)
- 605 Equity and Justice Initiatives for International Medical Graduates (F)
- 701 Reconsideration of the Birthday Rule (G)
- 702 Providing Reduced Parking for Patients (G)
- 703 Tribal Health Program Electronic Health Record Modernization (G)
- 704 Interrupted Patient Sleep (G)
- 705 Aging and Dementia Friendly Health Systems (G)
- 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis (G)
- 707 Expediting Repairs for Power and Manual Wheelchairs (G)
- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures (G)
- 709 Hospital Bans on Trial of Labor After Cesarean (G)

**DECLARATION OF PROFESSIONAL RESPONSIBILITY:
MEDICINE'S SOCIAL CONTRACT WITH HUMANITY**

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.
2. Refrain from supporting or committing crimes against humanity and condemn all such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and polity about present and future threats to the health of humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications

- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities

- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

SEATING ALLOCATION – 2023 ANNUAL MEETING

ADDICTION MEDICINE – 3

American Society of Addiction Medicine (ASAM) – 3
Trustee (Levin) – 1
Delegates - 2

AMDA – 2

AMDA – The Society for Post-Acute and Long-Term Care
Medicine (AMDA) – 2

AMGA - 1

American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11

American Society of Anesthesiologists (ASA) - 9
Former Board Chair (Patchin) – 1
Delegates – 8
American Society of Regional Anesthesia and Pain
Medicine (ASRAPM) - 2

ARS – 1

American Rhinologic Society (ARS) - 1

CARDIOLOGY - 17

American College of Cardiology (ACC) - 7
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) – 2
Heart Rhythm Society (HRS) - 2
Society for Cardiovascular Angiography and Interventions
(SCAI) – 2
Society for Cardiovascular Magnetic Resonance
(SCMR) - 1
Society of Cardiovascular Computed Tomography
(SCCT) – 1

CHEST PHYSICIANS - 3

American College of Chest Physicians (CHEST)
(ACCP) - 3

CRITICAL CARE MEDICINE- 3

Society of Critical Care Medicine (SCCM) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

DERMATOLOGY - 11

American Academy of Dermatology (AAD) – 4
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery
(ASDS) - 3
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

EMERGENCY MEDICINE - 11

American College of Emergency Physicians (ACEP) - 11
Former President (Stack) - 1
Delegates - 8
Resident and Fellow Section Delegates - 2

ENDOCRINOLOGY - 3

American Association of Clinical Endocrinology
(AACE) - 1
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 18

American Academy of Family Physicians (AAFP) - 18
Former Board Chair (Langston) - 1
Delegates - 16
Resident and Fellow Section Delegate - 1

GASTROENTEROLOGY - 7

American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy
(ASGE) - 3

GERIATRIC MEDICINE - 3

American Geriatrics Society (AGS) – 3
Delegates – 2
Resident and Fellow Section Delegate - 1

GREAT LAKES - 66

Illinois - 17
Delegates - 12
Resident and Fellow Section Delegates - 2
American College of Legal Medicine (ACLM) - 1
American Med Women’s Association (AMWA) - 1
Society of Nuclear Medicine and Molecular Imaging
(SNMMI) - 1
Indiana - 6
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 18
Trustee (Mukkamala) - 1
Delegates - 14
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Ohio - 15
Delegates (minus Vice Speaker) - 13
Resident and Fellow Section Delegates – 2
Amer Assn of Neuromuscular & Electrodagnostic Med
(AANEM)- 1
Wisconsin - 10
Former Board Chair (Flaherty) - 1
Delegates - 5
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates - 2
Undersea & Hyperbaric Medical Society (UHMS) – 1

HEART OF AMERICA - 13

Kansas – 4
Delegates - 3
Medical Student Regional Delegate- 1
Missouri – 9
Former President (Barbe) - 1
Delegates - 6
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1

HEMATOLOGY - 2

American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3

Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 3

Infectious Diseases Society of America (IDSA) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

INTERNAL MEDICINE - 35

American College of Physicians (ACP) – 34
Delegates – 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 14

American Acad of Orthopaedic Surgeons (AAOS) – 5
Delegates – 5
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society
(AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians
(ASIPP) - 2
International Society for the Advancement of Spine Surgery
(ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES – 33

American Academy of Addiction Psychiatry (AAP) - 1
American Academy of Child and Adolescent Psychiatry
(AACAP) - 2
American Academy of Hospice and Palliative Medicine
(AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 4
Resident and Fellow Section Delegate - 1
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons
(AANS) - 4
Former President (Carmel) - 1
Delegates – 2
Resident and Fellow Section Delegate – 1
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ
Equality – 1
North American Neuromodulation Society (NANS) - 1
Spine Intervention Society (SIS) - 1

NEW ENGLAND - 30

Connecticut – 8
Trustee (Koirala) - 1
Delegates - 4
Medical Student Regional Delegates- 2
Resident and Fellow Section Delegate - 1
Maine - 3
Delegates – 2
Medical Student Regional Delegate - 1
Massachusetts - 15
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
New Hampshire - 1
Rhode Island - 2
Vermont – 1

NEW YORK - 28

Former President (Nielsen) – 1
Trustee (Madejski) – 1
Delegates - 22
Medical Student Regional Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 17

Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society
(OEIS) - 1
Minnesota – 6
Delegates - 5
Medical Student Regional Delegate- 1
Nebraska – 3
Delegates – 2
Resident and Fellow Section Delegate - 1
North Dakota - 1
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 19

American Association of Gynecologic Laparoscopists
(AAGL) - 3
American College of Medical Genetics and Genomics
(ACMGG) - 1
American College of Obstetricians and Gynecologists
(ACOG) – 14
Delegates – 14
Former President (Wah)
American Soc for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 5

Association for Clinical Oncology (ACO) – 5
Delegates – 5
Former President (McAneny)

PACWEST CONFERENCE – 86

Alaska - 1
Arizona - 8
Delegates – 5
American Coll of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine
(AIUM) – 2
California - 43
Former Presidents (Bristow, Corlin) – 2
Trustee (Aizuss, Ding) - 2
Delegates - 33
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
North American Neuro-Ophthalmology Society
(NANOS) – 1
Colorado - 7
Delegates - 6
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 4
Delegates - 2
Resident and Fellow Section Delegates – 2

PACWEST CONFERENCE (cont’d)

New Mexico – 4
Delegates – 2
Resident and Fellow Section Delegate - 1
American Academy of Allergy, Asthma & Immunology
(AAAAI) – 1
Oregon – 5
Delegates - 4
Medical Student Regional Delegate- 1
Utah - 2
Washington – 7
Delegates – 6
Medical Student Regional Delegate - 1
Wyoming – 1

PATHOLOGY - 11

American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1
United States and Canadian Academy of Pathology
(USCAP) – 2

PEDIATRICS - 7

American Academy of Pediatrics (AAP) – 7
Trustee (Ajayi) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 19

Trustee (Heine) - 1
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
American Association of Physicians of Indian Origin
(AAPIO) – 1
American Hernia Society (AHS) - 1
National Medical Association (NMA) - 1

PHYSICAL MEDICINE AND REHABILITATION - 2

American Academy of Physical Med & Rehabilitation
(AAPMR) – 2

PREVENTIVE MEDICINE - 8

Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians
(AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med
(ACOEM) - 2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 19

American College of Radiology (ACR) – 8
Delegates – 8
Former President (Johnson)
American Roentgen Ray Society (ARRS) – 3
American Soc for Radiation Oncology (ASRO) – 2
Association of University Radiologists (AUR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2

American College of Rheumatology (ACRrh) - 2

SECTIONS - 12

Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
Trustee (Harvey) - 1
Delegate – 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) – 1
Private Practice Physician Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS)-1
Young Physicians Section (YPS) - 1

SERVICES - 6

Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2

American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 121

Alabama – 5
Delegates - 4
Medical Student Regional Delegate- 1
Arkansas – 4
Trustee (Ferguson) – 1
Delegates - 3
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 5
Former Board Chair (Scalettar) - 1
Delegates - 3
Resident and Fellow Section Delegate - 1
Florida – 21
Former President (Coble) – 1
Trustee (Butler) - 1
Delegates – 17
Medical Student Regional Delegate- 1
The Triological Society (TS) - 1
Georgia – 6
Kentucky - 7
Former President (Hoven) - 1
Delegates (minus Speaker) – 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Louisiana - 7
Delegates - 6
Medical Student Regional Delegate- 1
Maryland - 9
Trustee (Edwards) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1

SOUTHEASTERN (cont’d)

Mississippi - 4
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey - 11
Delegates - 8
Medical Student Regional Delegate- 1
American Acad of Facial Plastic and Reconstructive Surgery
(AAFPRS) – 1
American Osteopathic Association (AOA) – 1
North Carolina – 7
Delegates - 6
Medical Student Regional Delegate- 1
Oklahoma – 5
Delegates - 4
Medical Student Regional Delegate- 1
Puerto Rico - 2
South Carolina – 8
Former President (Smoak) – 1
Trustee (Pastides) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Tennessee – 7
Delegates – 6
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 9
Delegates - 8
Medical Student Regional Delegate- 1
West Virginia – 2

SURGEONS - 44

American Academy of Cosmetic Surgery (AACCS) - 1
American Academy of Ophthalmology (AAO) – 4
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery
(AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) – 7
American Society for Aesthetic Plastic Surgery
(ASAPS) – 1
American Society for Metabolic and Bariatric Surgery
(ASMBS) - 1
American Society for Reconstructive Microsurgery
(ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 2
American Society of Cataract and Refractive Surgery
(ASCRS) - 2
American Society of Colon and Rectal Surgeons
(ASCRS) - 2
American Society of General Surgeons (ASGS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg
(ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 3
American Society of Retina Specialists (ASRS) - 2
American Society of Transplant Surgeons (ASTS) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons
(SAGES) - 2
Society of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2

Guam - 1
Virgin Islands - 1

TEXAS - 29

Former Presidents (Bailey, Dickey, Rohack) - 3
Former Board Chair (Kridel) – 1
Delegates - 20
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegates – 2
American College of Allergy, Asthma & Immunology
(ACAAI) – 1
International Society of Hair Restoration Surgery
(ISHRS) – 1

THORACIC MEDICINE - 2

American Thoracic Society (ATS) - 2

UROLOGY - 4

American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) – 3
Delegates -2
Resident and Fellow Section Delegate – 1

OFFICIAL OBSERVERS - 28

Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health
Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia

TELLERS - 6

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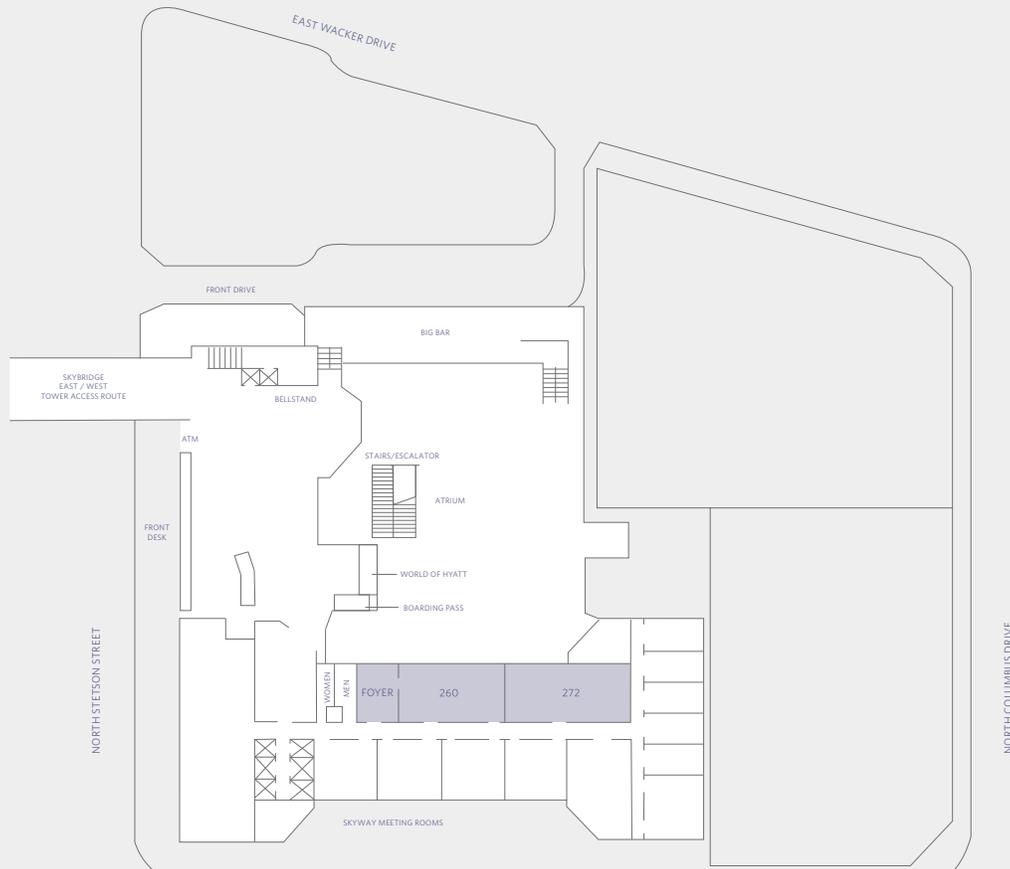


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (East Tower)										
SKYWAY MEETING ROOMS										
Skyway Foyer	27'9" x 21'4" x 9'	507	—	40	—	—	6	—	—	—
Skyway 260	23'3" x 43'1" x 9'	961	40	100	51	36	30	—	—	—
Skyway 272	23'3" x 41'2" x 9'	811	40	70	45	36	28	—	—	—

FLOOR PLAN



Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

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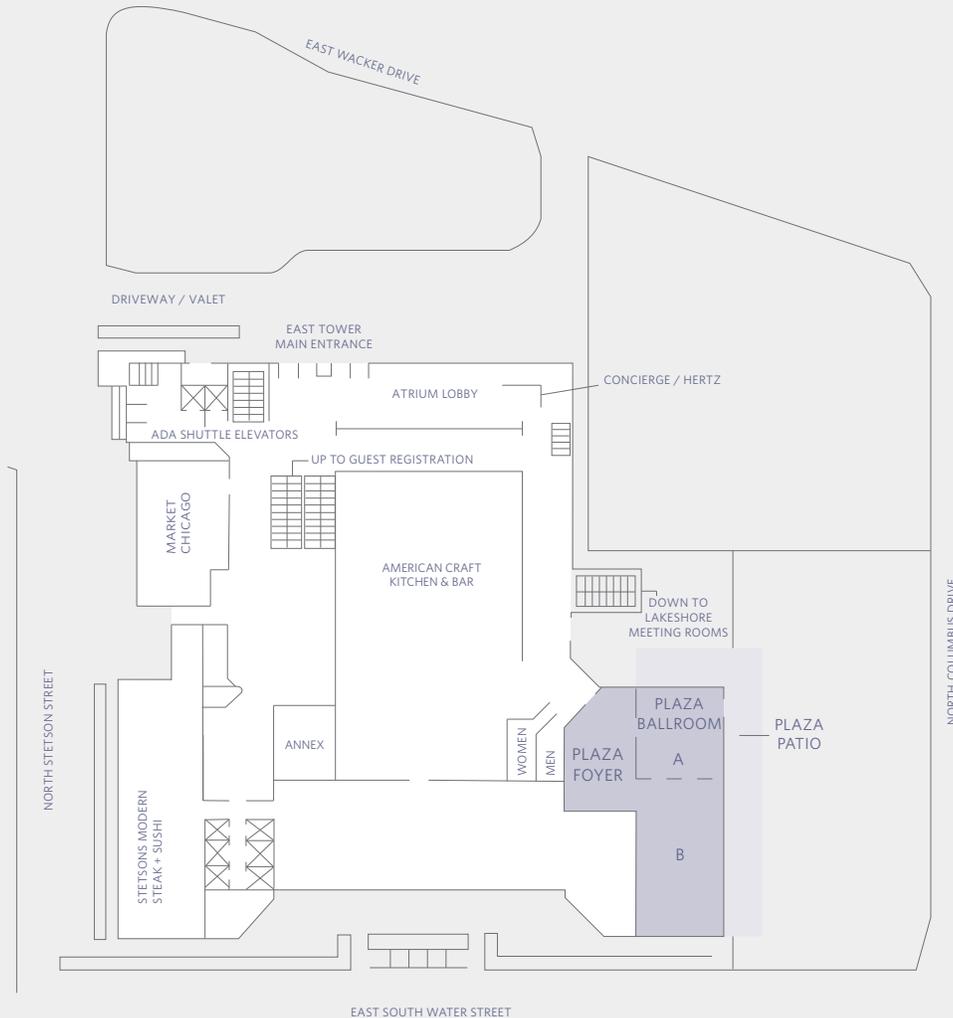


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Lobby Level (East Tower)										
PLAZA BALLROOM	92'9" x 28'9" x 10'6"	2,652	140	250	200	159	60	70	72	—
Plaza A	39'3" x 28'9" x 10'6"	1,128	60	130	70	63	24	30	32	—
Plaza B	53' x 28'9" x 10'6"	1,524	80	150	130	96	36	40	40	—
Plaza Patio	34'5" x 115'3" x 9"	1,925	—	—	—	—	—	—	—	—
Plaza Park	— x — x —	—	—	—	—	—	—	—	—	—

FLOOR PLAN



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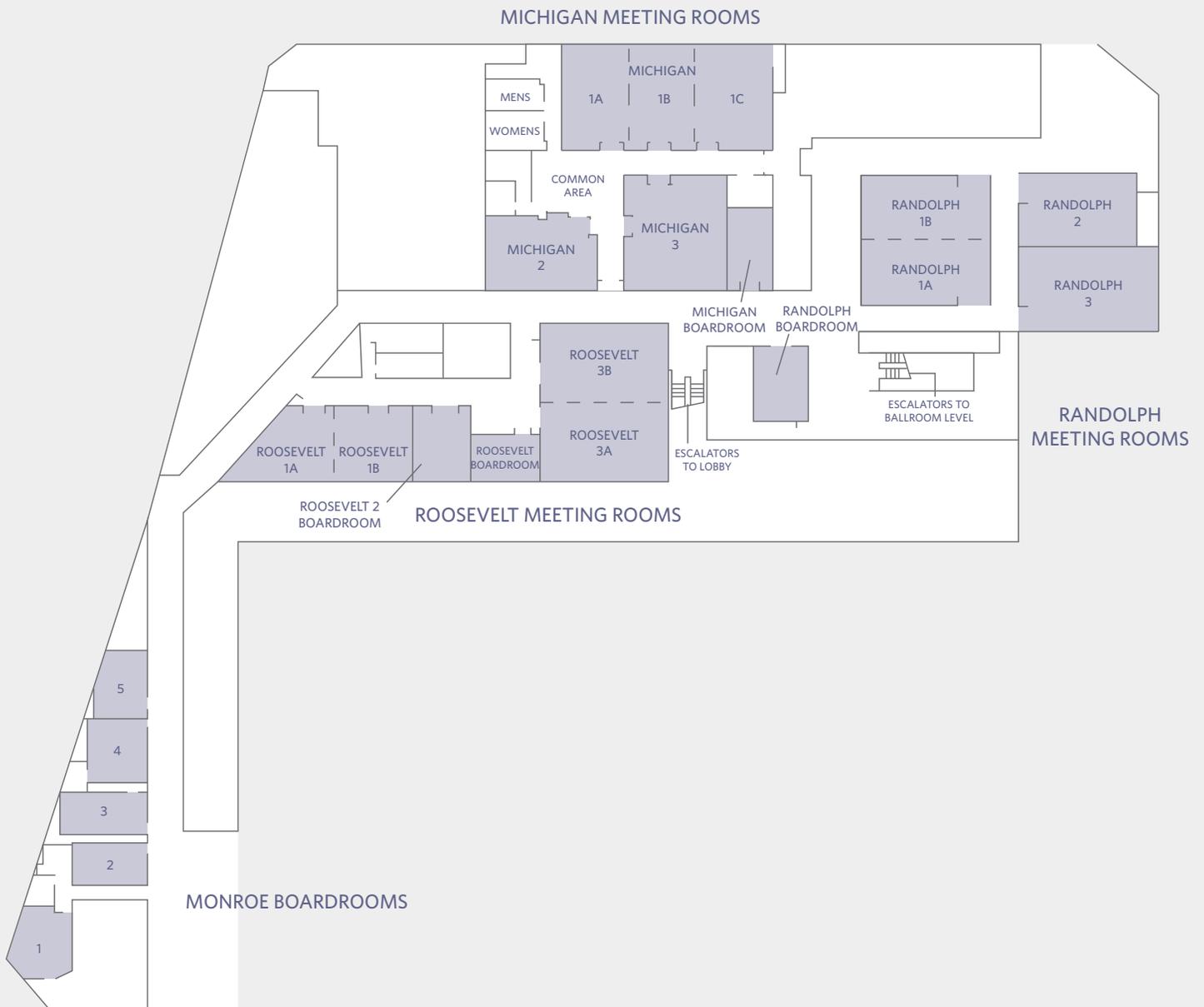
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Concourse Level (East Tower)										
LAKESHORE MEETING ROOMS										
Michigan 1A, 1B, 1C	33'4" x 74'5" x 8'6"	2,475	140	250	270	135	40/50*	69	78	—
Michigan 1A	33'4" x 25' x 8'6"	825	50	80	66	42	22	21	24	—
Michigan 1B	33'4" x 24.5' x 8'6"	760	50	75	66	42	22	21	24	—
Michigan 1C	33'4" x 25.5' x 8'6"	841	50	80	66	42	22	21	24	—
Michigan 2	26.5' x 39' x 8'6"	1,033	50	100	80	50	28	24	30	—
Michigan 3	41.5' x 34' x 8'6"	1,390	60	135	90	60	34	30	36	—
Michigan Boardroom	26' x 15' x 8'6"	390	—	—	—	—	12	—	—	—
Randolph 1A & 1B	33' x 46' x 8'6"	1,767	100	175	108	60	40	40	48	—
Randolph 1A	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 1B	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 2	36' x 26'9" x 8'6"	922	50	90	60	30	28	24	30	—
Randolph 3	42' x 29'10" x 8'6"	1,192	70	120	84	48	34	30	36	—
Randolph Boardroom	23' x 16' x 8'6"	368	—	—	—	—	10	—	—	—
Roosevelt 1A & 1B	27'6" x 42' x 8'6"	1,186	60	125	70	42	40	39	42	—
Roosevelt 1A	27'6" x 26'16" x 8'6"	599	30	50	28	18	28	18	21	—
Roosevelt 1B	27'6" x 26' x 8'6"	587	30	70	32	18	28	15	18	—
Roosevelt 2 Boardroom	25' x 17' x 8'6"	425	—	—	—	—	12	—	—	—
Roosevelt Boardroom	17' x 21' x 8'6"	357	—	—	—	—	8	—	—	—
Roosevelt 3A & 3B	30' x 55' x 8'6"	1,650	100	165	132	78	52	54	60	9
Roosevelt 3A	30' x 28' x 8'6"	840	40	80	60	42	28	24	36	—
Roosevelt 3B	30' x 27' x 8'6"	810	40	80	60	42	28	24	36	—
Monroe 1 Boardroom	24'6" x 19'9" x 8'6"	400	—	—	—	—	10	—	—	—
Monroe 2 Boardroom	20'6" x 15' x 8'6"	307	—	—	—	—	8	—	—	—
Monroe 3 Boardroom	24'6" x 15' x 8'6"	367	—	—	—	—	12	—	—	—
Monroe 4 Boardroom	18' x 22'6" x 8'6"	405	—	—	—	—	10	—	—	—
Monroe 5 Boardroom	16' x 21' x 8'6"	336	—	—	—	—	14	—	—	—

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FLOOR PLAN
Concourse Level (East Tower)



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CAPACITY CHART



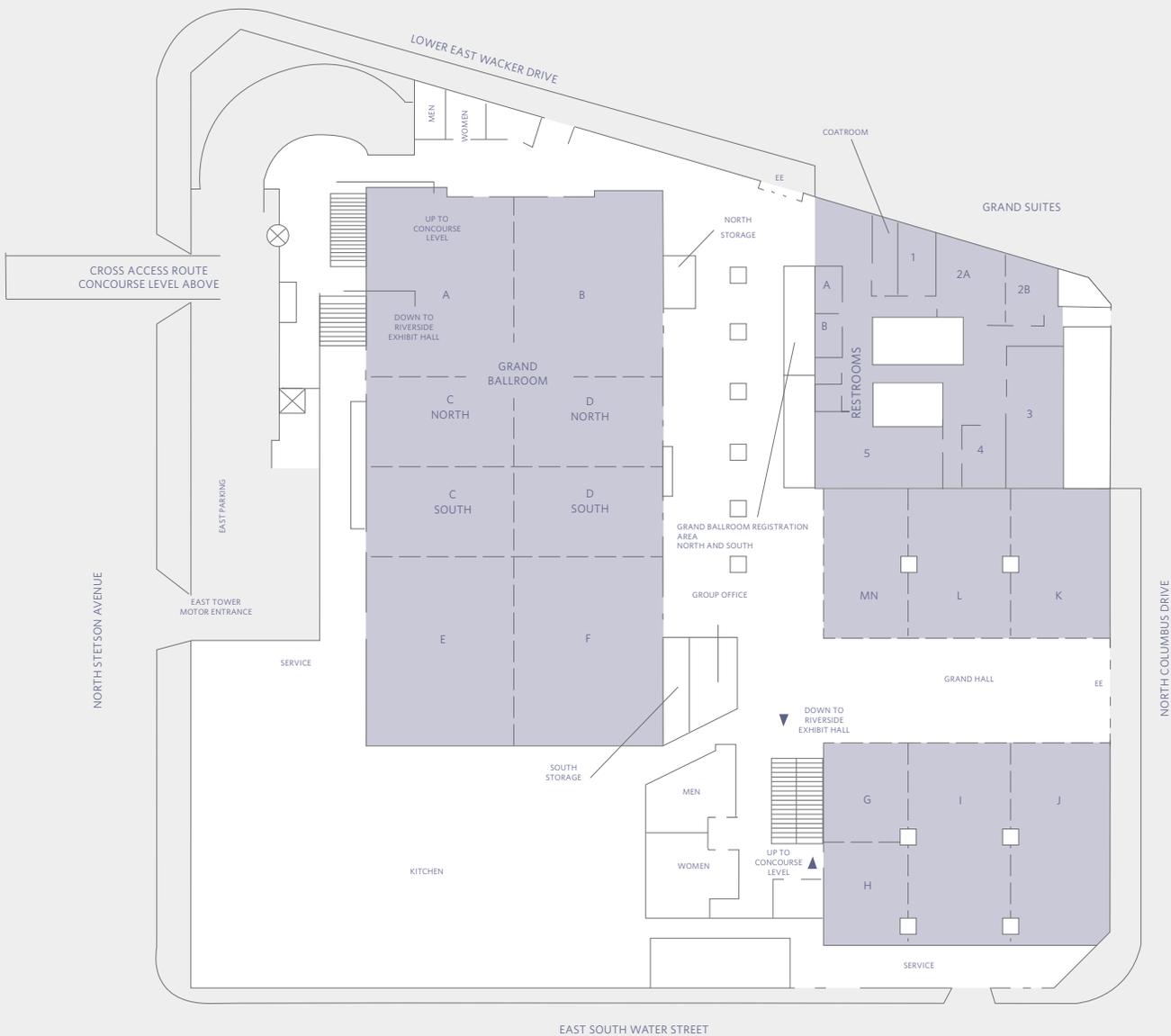
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Ballroom Level (East Tower)										
GRAND BALLROOM	213' x 114' x 17'	24,282	1,800	3,000	2,400	1,250	—	—	—	137
Grand A or B	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand AB	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
Grand C or D	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand CD	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	51
Grand C or D North	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand C or D South	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand CD North or South	36' x 114' x 17'	4,047	280	400	400	250	74	80	100	25
Grand E or F	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand EF	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
GRAND HALL	110'4" x 169'5" x 9'6"	17,628	1,250	1,800	—	—	—	—	—	93
Grand Hall G or H	37'8" x 34'6" x 9'6"	1,263	50	115	80	34	34	34	40	—
Grand Hall GH	76'8" x 34'6" x 9'6"	2,551	150	250	210	129	62	70	80	12
Grand Hall I	76'8" x 36'11" x 9'6"	2,798	170	250	225	144	70	70	80	12
Grand Hall J	76'8" x 36'11" x 9'6"	2,873	170	250	225	144	70	70	80	12
Grand Hall K	60'3" x 37'7" x 9'6"	2,310	120	225	180	108	58	60	65	12
Grand Hall L	60'3" x 37'7" x 9'6"	2,243	120	200	180	108	58	55	60	12
Grand Hall MN	60'3" x 37'7" x 9'6"	1,951	120	200	180	108	52	55	60	12
GRAND SUITES	38'5" x 9'6"									
Grand Suite 1	14' x 19' x 11'	264	10	25	16	—	8	—	—	—
Grand Suite 2A	20'9" x 25'9" x 11'	523	30	35	30	24	10	6	12	—
Grand Suite 2B	16'3" x 14' x 11'	238	10	15	15	9	8	—	—	—
Grand Suite 2AB	42'5" x 20'9" x 11'	764	40	75	60	30	14	12	18	—
Grand Suite 3	25' x 57' x 9'	1,425	80	130	120	60	40	32	36	—
Grand Suite 4	14' x 23' x 9'	322	—	—	—	—	8	—	—	—
Grand Suite 5	23' x 49' x 11'	1,127	70	100	96	60	30	22	25	—

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FLOOR PLAN
 Ballroom Level (East Tower)



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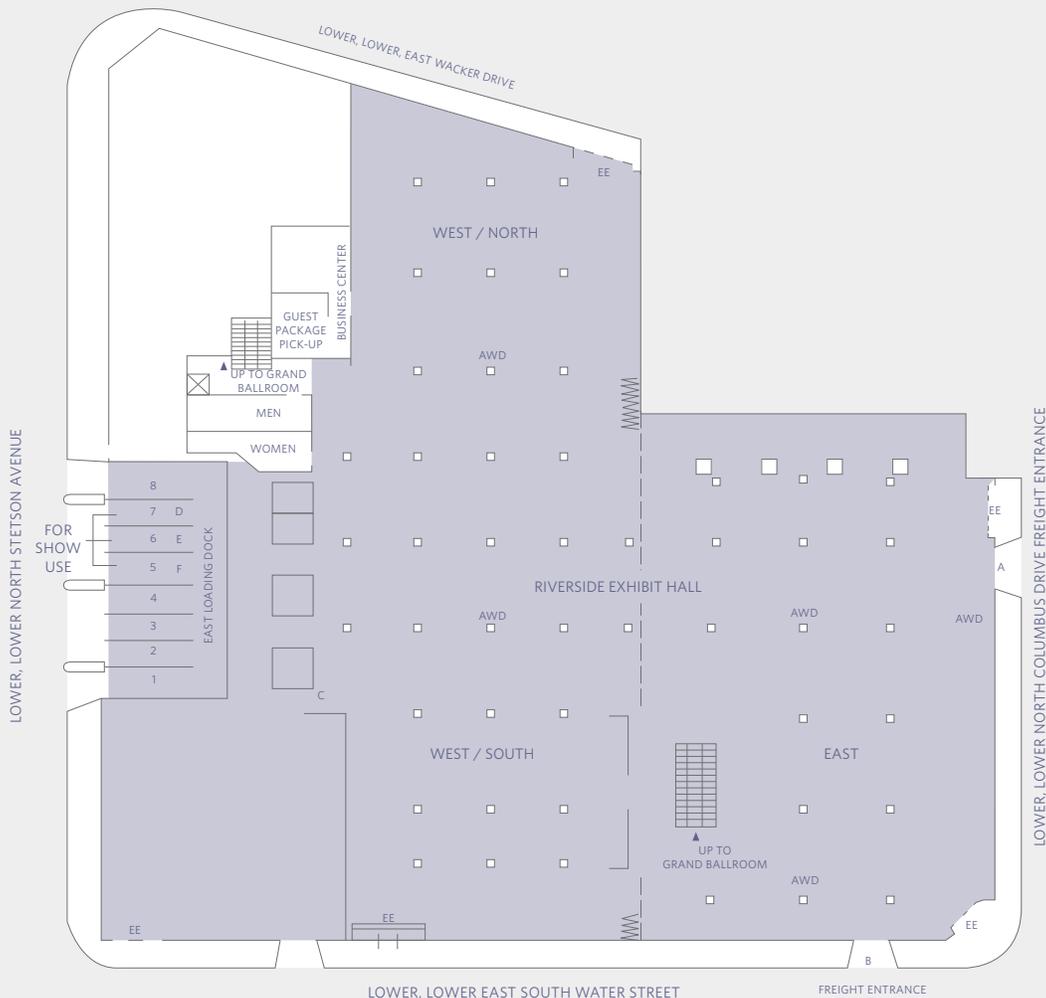


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Exhibit Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,330	7,000	—	—	—	—	—	355
EAST	—	30,000	870	2,500	2,400	—	—	—	—	151
WEST	—	40,000	1,330	4,500	3,300	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—

FLOOR PLAN



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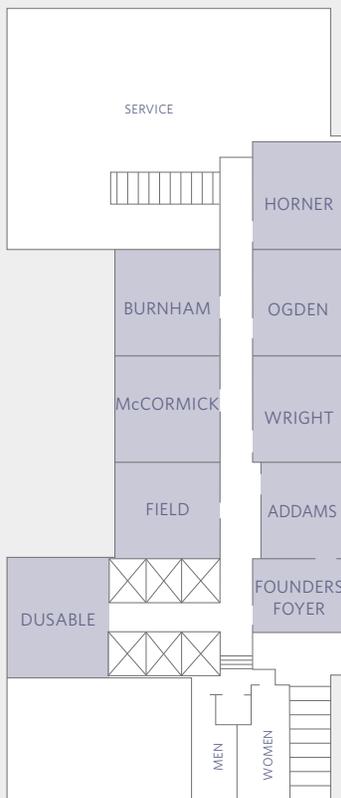


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Third Floor (West Tower)										
FOUNDERS SUITES										
Dusable	26'5" x 26'7" x 9'	677	40	60	50	27	28	18	30	—
Field	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
McCormick	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
Burnham	25'5" x 24' x 10'	688	40	60	50	27	28	18	30	—
Addams	22' x 24'10" x 9'	556	40	50	32	18	20	15	18	—
Wright	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Ogden	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Horner	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Founders Foyer	16' x 23'10" x 9'	446	—	—	—	—	8	—	—	—

FLOOR PLAN



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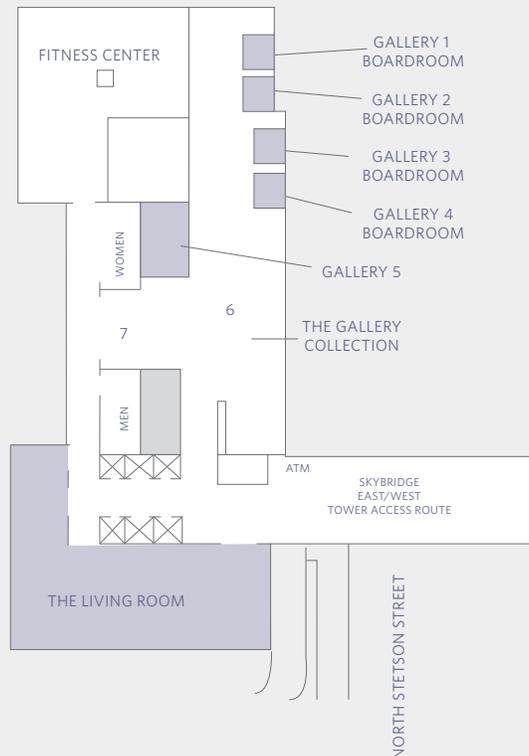


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (West Tower)										
THE LIVING ROOM	—	—	—	—	—	—	—	—	—	—
GALLERY COLLECTION										
The Gallery Lounge 6	23' x 52'10"	1,206	—	—	—	—	—	—	—	—
The Gallery Lounge 7	32'2" x 24'2"	759	—	—	—	—	—	—	—	—
Gallery 1 Boardroom	21'4" x 10'4"	223	—	—	—	—	10	—	—	—
Gallery 2 Boardroom	21'4" x 11'4"	251	—	—	—	—	10	—	—	—
Gallery 3 Boardroom	21'4" x 12'2"	258	—	—	—	—	10	—	—	—
Gallery 4 Boardroom	21'4" x 11'10"	284	—	—	—	—	10	—	—	—
Gallery 5	17'9" x 28'4"	470	20	40	30	24	18	—	—	—

FLOOR PLAN



Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

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 151 East Wacker Drive
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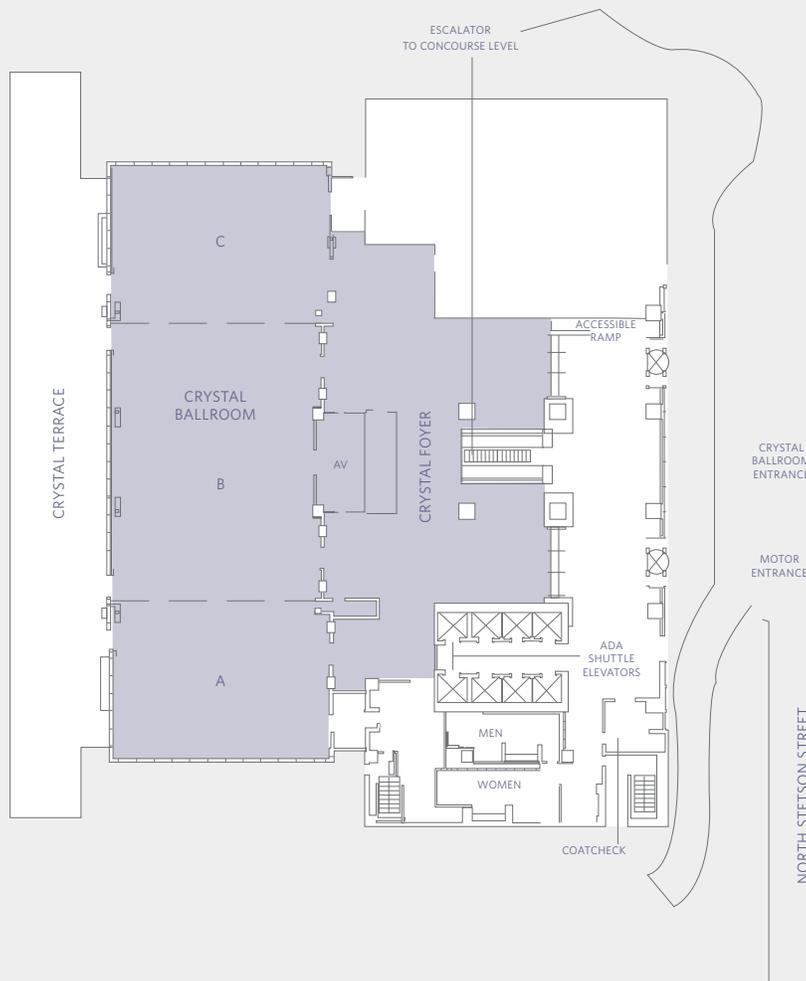


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Lobby Level (West Tower)										
CRYSTAL BALLROOM	167' x 59' x 19'	9,853	700	1,000	950	500	—	—	—	40
Crystal A	43' x 59' x 19'	2,584	160	250	280	125	50	56	66	—
Crystal B	80' x 56' x 19'	4,559	320	500	450	240	100	70	82	—
Crystal C	43' x 59' x 19'	2,586	160	250	280	125	50	56	66	—
Crystal AB or BC	123' x 59' x 19'	7,198	480	750	870	380	120	129	150	—
CRYSTAL FOYER	—	5,120	—	400	—	—	—	—	—	—

FLOOR PLAN



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CAPACITY CHART

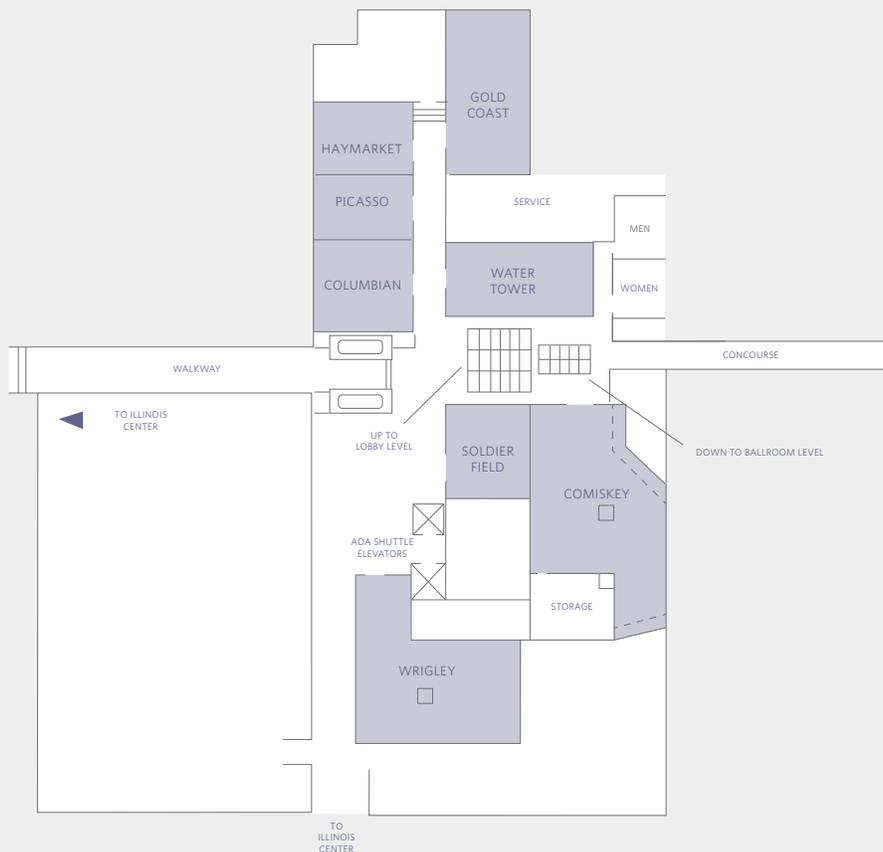


Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
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Concourse Level (West Tower)

LANDMARK SUITES										
Comiskey	40' x 62' x 9'	1,982	70	200	90	84	40	36	42	—
Water Tower	45'3" x 25' x 9'	1,143	80	120	120	54	28	26	36	—
Gold Coast	47'6" x 25' x 9'	1,178	80	120	120	54	28	26	36	—
Haymarket	29'6" x 19'6" x 9'	562	40	60	30	24	24	20	25	—
Picasso	29'6" x 22' x 9'	599	40	60	30	30	24	18	24	—
Columbian	27'3" x 25' x 9'	681	40	60	60	33	26	25	30	—
Soldier Field	34' x 25'8 x 9'	789	40	70	45	30	24	25	30	—
Wrigley	43' x 52' x 9'	1,540	70	140	60	48	30	25	30	—

FLOOR PLAN



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CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Ballroom Level (West Tower)										
REGENCY BALLROOM	72' x 230' x 11'8"	16,560	1,000	1,600	1,600	750	—	—	—	90
Regency A, B, C or D	72' x 58' x 11'8"	4,176	240	400	400	220	70	72	100	20
Regency AB, BC or CD	72' x 117' x 11'8"	8,424	480	800	800	450	140	144	200	40
Regency ABC or BCD	72' x 174' x 11'8"	12,528	750	1,200	1,200	675	—	—	—	60
INTERNATIONAL SUITES	59'6" x 81'3" x 7'6"	3,936	240	350	—	—	—	—	—	22
Toronto	59'6" x 26'6" x 8'5"	1,558	100	150	120	96	55	55	60	10
Hong Kong	28' x 27' x 8'5"	808	40	50	60	36	30	23	28	3
Acapulco	59'6" x 27' x 8'5"	1,558	100	150	120	96	55	55	60	10
CITY SUITES										
Atlanta	24' x 32' x 7'9"	768	40	60	60	36	24	18	24	—
San Francisco	25' x 26' x 7'9"	650	40	60	55	27	24	29	32	—
New Orleans	28' x 33' x 7'9"	906	50	70	65	45	30	24	30	—
West Tower (36th Floor)										
BOARD OF TRADE	23' x 27'	621	—	—	—	—	16	—	—	—

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FLOOR PLAN
Ballroom Level (West Tower)



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CAPACITY CHART

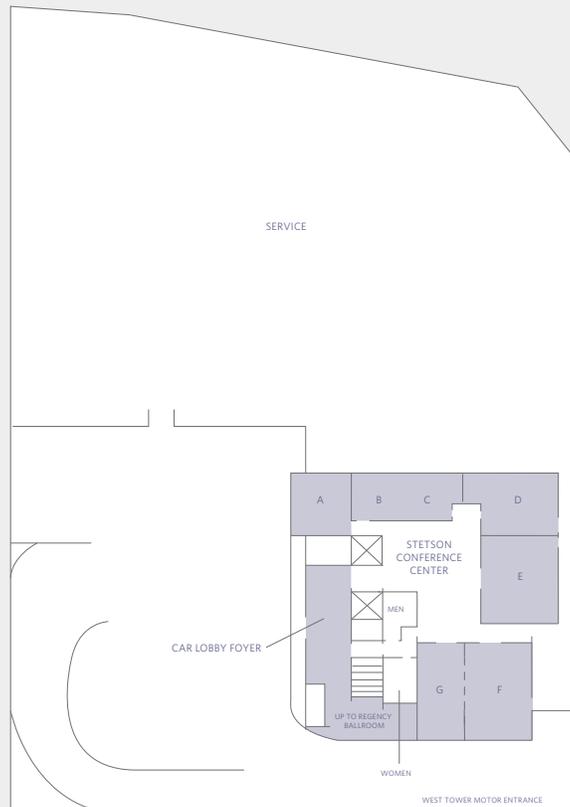


Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
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Exhibit Level (West Tower)

STETSON CONFERENCE CENTER										
Stetson Suite A	9' x 19' x 8'	378	10	25	24	15	12	—	—	—
Stetson Suite BC	30' x 17' x 8'	510	30	40	45	18	24	27	30	—
Stetson Suite D	18' x 24' x 8'	432	10	25	30	18	20	10	12	—
Stetson Suite E	30' x 27' x 8'	810	40	55	50	21	26	14	16	—
Stetson Suite F	36' x 25' x 8'	900	50	60	70	45	34	18	20	—
Stetson Suite G	36' x 14' x 8'	504	30	40	48	27	14	14	14	—
Stetson Suite F-G	36' x 39' x 8'	1,404	80	90	—	—	—	—	—	—

FLOOR PLAN



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2023 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2023 Annual Meeting of the House of Delegates in Chicago, Illinois, June 9 - 14, 2023.

The House of Delegates will convene at 6:00 p.m., on June 9 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 22	Tennessee 6
Alaska 1	Hawaii 2	Michigan 14	North Carolina 6	Texas 20
Arizona 5	Idaho 1	Minnesota 5	North Dakota 1	Utah 2
Arkansas 3	Illinois 12	Mississippi 3	Ohio 13	Vermont 1
California 33	Indiana 5	Missouri 6	Oklahoma 4	Virgin Islands 1
Colorado 6	Iowa 4	Montana 1	Oregon 4	Virginia 8
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 13	Washington 6
Delaware 1	Kentucky 5	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 3	Louisiana 6	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 17	Maine 2	New Jersey 8	South Carolina 5	Wyoming 1
Georgia 6	Maryland 6	New Mexico 2	South Dakota 2	

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2	American Society for Gastrointestinal Endoscopy 3
American Academy of Child and Adolescent Psychiatry 2	American Society for Radiation Oncology 2
American Academy of Dermatology 4	American Society of Addiction Medicine 2
American Academy of Family Physicians 16	American Society of Anesthesiologists 8
American Academy of Hospice and Palliative Medicine 2	American Society of Breast Surgeons 2
American Academy of Neurology 4	American Society of Cataract and Refractive Surgery 2
American Academy of Ophthalmology 4	American Society of Colon and Rectal Surgeons 2
American Academy of Orthopaedic Surgeons 5	American Society of Echocardiography 2
American Academy of Otolaryngology-Head and Neck Surgery 3	American Society of Hematology 2
American Academy of Pediatrics 5	American Society of Interventional Pain Physicians 2
American Academy of Physical Medicine and Rehabilitation 2	American Society of Neuroradiology 2
American Academy of Sleep Medicine 2	American Society of Nuclear Cardiology 2
American Association of Gynecologic Laparoscopists 3	American Society of Plastic Surgeons 3
American Association of Neurological Surgeons 2	American Society of Retina Specialists 2
American College of Cardiology 7	American Thoracic Society 2
American College of Chest Physicians (CHEST) 3	American Urological Association 2
American College of Emergency Physicians 8	Association for Clinical Oncology 5
American College of Gastroenterology 2	College of American Pathologists 4
American College of Obstetricians and Gynecologists 14	Congress of Neurological Surgeons 2
American College of Occupational and Environmental Medicine 2	Heart Rhythm Society 2
American College of Physicians 34	Infectious Diseases Society of America 2
American College of Radiology 8	North American Spine Society 2
American College of Rheumatology 2	Radiological Society of North America 3
American College of Surgeons 7	Society for Cardiovascular Angiography and Interventions 2
American Gastroenterological Association 2	Society of American Gastrointestinal Endoscopic Surgeons 2
American Geriatrics Society 2	Society of Critical Care Medicine 2
American Institute of Ultrasound in Medicine 2	Society of Hospital Medicine 3
American Psychiatric Association 8	Society of Interventional Radiology 2
American Roentgen Ray Society 3	Society of Laparoscopic and Robotic Surgeons 2
American Society for Clinical Pathology 3	Society of Thoracic Surgeons 2
American Society for Dermatologic Surgery 3	The Endocrine Society 2
	United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (65) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	313
National Medical Specialty Societies	311
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	35
Sections	11
Services	5
Total Delegates	708

Registration facilities will be maintained at the Hyatt Regency Chicago in the Grand Ballroom Foyer.

Jack Resneck, Jr., MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Michael Suk, MD, JD, MPH, MBA
Secretary

2022 - 2023

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Jack Resneck San Rafael, California
President-Elect - Jesse M. Ehrenfeld Milwaukee, Wisconsin
Immediate Past President - Gerald E. Harmon Pawleys Island, South Carolina
Secretary - Michael Suk Danville, Pennsylvania
Speaker, House of Delegates - Bruce A. Scott Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert Kettering, Ohio

David H. Aizuss (2024) Encino, California
Toluwalase A. Ajayi (2026) San Diego, California
Madelyn E. Butler (2025) Tampa, Florida
Alexander Ding (2026) Louisville, Kentucky
Willarda V. Edwards (2024) Baltimore, Maryland
Scott Ferguson (2026) West Memphis, Arkansas
Sandra Adamson Fryhofer (2026), *Chair* Atlanta, Georgia
Drayton Charles Harvey (2023) Los Angeles, California
Marilyn J. Heine (2026) Dresher, Pennsylvania
Pratistha Koirala (2023) Danbury, Connecticut
Ilse R. Levin (2024) Silver Spring, Maryland
Thomas J. Madejski (2024) Medina, New York
Bobby Mukkamala (2025) Flint, Michigan
Harris Pastides (2024) Columbia, South Carolina
Willie Underwood, III (2023), *Chair-Elect* Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS

Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Chair (2026); Mark N. Bair, Highland, Utah, Vice Chair, (2023);
Jerry P. Abraham, Los Angeles, California (2025); Pino D. Colone, Howell, Michigan (2024);
Mary Ann Contogiannis, Greensboro, North Carolina (2025); Titus Hou, Chicago, Illinois (Student) (2023);
Christopher P. Libby, Anaheim, California (Resident) (2024); Steven C. Thornquist, Bethany, Connecticut (2026).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Peter A. Schwartz, Reading, Pennsylvania, Chair (2023); David A. Fleming, Columbia, Missouri, Vice Chair
(2024); Rebecca W. Brendel, Boston, Massachusetts (2026); Michael G. Knight, Washington, DC (2029);
Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey C. Mumford, Washington, DC (Student) (2023);
Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi,
New Haven, CT (Resident) (2024).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION

Heather Ann Smith, Newport, Rhode Island, Chair (2023); Gary W. Floyd, Corpus Christi, Texas, Vice Chair,
(2023); Vijaya L. Appareddy, Chattanooga, Tennessee (2023); Maryanne C. Bombaugh, Falmouth, Massachusetts
(2023); Benjamin Z. Galper, McLean, Virginia (AMPAC Liaison) (2023); Mary S. Carpenter, Winner,
South Dakota (2023); John R. Gatti, Baltimore, Maryland (Student) (2024); Merrilee Aynes Gober, Atlanta, Georgia
(Alliance Rep) (2023); Ross F. Goldberg, Scottsdale, Arizona (2023); Tracy L. Henry, Lithonia, Georgia (2023);
Tripti C. Kataria, Chicago, Illinois (2023); Sophia E. Spadafore, New York, New York (Resident) (2023); Ann
Rosemarie Stroink, Bloomington, Illinois (2023); Marta J. Van Beek, Iowa City, Iowa (2023).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

Edmond B. Cabbabe, St. Louis, Missouri, Chair (2025); Gary D. Thal, Chicago, Illinois, Vice Chair (2025); John H. Armstrong, Ocala, Florida (2025); Rijul Asri, Princeton, New Jersey (Student) (2023); Michelle A. Berger, Austin, Texas (2026); Clarence P. Chou, Mequon, Wisconsin (2024); Jan M. Kief, Merritt Island, Florida (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Shannon P. Pryor, Chevy Chase, Maryland (2024); Stephanie M. Strohbeen, Whitefish Bay, Wisconsin (Resident) (2024).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION

John P. Williams, Gibsonia, Pennsylvania, Chair (2023); Cynthia A. Jumper, Lubbock, Texas, Chair Elect (2024); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New Jersey (2025); Shannon M. Kilgore, Palo Alto, California (2023); Suja M. Matthew, Hinsdale, Illinois (2026); David J. Savage, La Jolla, California (Resident) (2023); Aliya Siddiqui, Glen Ellyn, Illinois (Student) (2023); Krystal L. Tomei, Lyndhurst, Ohio (2025).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE

Lynn L. C. Jeffers, Camarillo, California, Chair (2024); Sheila Rege, Pasco, Washington, Chair Elect (2026); Patrice Burgess, Boise, Idaho (2023); Alain A. Chaoui, Boxford, Massachusetts (2025); Steven L. Chen, San Diego, California (2024); Betty S. Chu, Birmingham, Michigan (2026); Alice Coombs, Richmond, Virginia (2023); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts (2026); Ravi Goel, Cherry Hill, New Jersey (2026); Vinita Shivakumar, Stanford, California (Student) (2023); Megan L. Srinivas, Fort Dodge, Iowa (Resident) (2023).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH

Noel N. Deep, Antigo, Wisconsin, Chair (2023); David J. Welsh, Batesville, Indiana, Chair Elect (2024); Joanna Bisgrove, Evanston, Illinois (2026); John T. Carlo, Dallas, Texas (2025); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Karen Dionesotes, Baltimore, Maryland (Resident) (2024); Mary E. LaPlante, Broadview Heights, Ohio (2025); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2026); Corliss A. Varnum, Oswego, New York (2023); Christopher K. Wong, Houston, Texas (Student) (2023).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE

Brooke M. Buckley, Bloomfield Hills, Michigan, Chair; L. Elizabeth Peterson, Spokane, Washington, Secretary; Elie C. Azrak, St. Louis, Missouri; Paul J. Carniol, Summit, New Jersey; Ricardo R. Correa, Westlake, Ohio; Juliana Cobb, Louisville, Kentucky (Student); Benjamin Z. Galper, McLean, Virginia; Bruce A. MacLeod, Pittsburgh, Pennsylvania; Stephen J. Rockower, Bethesda, Maryland; Sion Roy, Malibu, California; Janice E. Tildon-Burton, Wilmington, Delaware; Victoria Gordon, Houston, Texas (Resident).
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	J. Edward Hill	2005-2006	William G. Plested, III	2006-2007
David O. Barbe	2017-2018	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Lonnie R. Bristow	1995-1996	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Peter W. Carmel	2011-2012	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Yank D. Coble, Jr.	2002-2003	Robert E. McAfee	1994-1995	Robert M. Wah	2014-2015
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Cecil B. Wilson	2010-2011
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Percy Wootton	1997-1998
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005		
Patrice A. Harris	2019-2020	Nancy H. Nielsen	2008-2009		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Rebecca J. Patchin	1988-1989
Susan Hershberg Adelman	1998-2002	William A. Hazel, Jr.	2004-2009	Rebecca J. Patchin	2003-2011
Kendall S. Allred	2008-2009	Cyril M. Hetsko	2003-2011	Stephen R. Permut	2010-2018
Raj S. Ambay	2009-2011	J. Edward Hill	1996-2004	Pamela Petersen-Crair	1996-1998
Joseph P. Annis	2006-2014	Ardis D. Hoven	2005-2012	Dina Marie Pitta	2015-2016
Grayson W. Armstrong	2019-2021	William E. Jacott	1989-1998	William G. Plested, III	1998-2005
John H. Armstrong	2002-2006	Hillary D. Johnson	2001-2002	Stephen Pool	1995-1996
Maya A. Babu	2013-2017	Matthew D. Kagan	1999-2000	Liana Puscas	1999-2001
Susan R. Bailey	2011-2018	Christopher K. Kay	2008-2012	Kevin C. Reilly	2003-2005
Timothy E. Baldwin	1987-1989	William E. Kobler	2012-2020	Ryan J. Ribeira	2013-2014
David O. Barbe	2009-2016	Russell W.H. Kridel	2014-2022	J. James Rohack	2001-2008
Regina M. Benjamin	1995-1998	Edward L. Langston	2003-2011	David A. Rosman	2002-2004
Scott L. Bernstein	1991-1992	Matthew C. Lawyer	2004-2005	Samantha L. Rosman	2005-2009
Stefano M. Bertozzi	1986-1988	Jeremy A. Lazarus	2005-2011	Raymond Scalettar	1985-1994
David J. Brailer	1985-1986	W. J. Lewis	1979-1984	Bruce A. Scott	1998-2002
Lonnie R. Bristow	1985-1994	Audrey J. Ludwig	1990-1991	Carl A. Sirio	2010-2018
Peter Carmel	2002-2010	Justin B. Mahida	2009-2010	Sarah Mae Smith	2019-2020
Alice A. Chenault	1984-1985	Omar Z. Maniya	2016-2017	Randolph D. Smoak, Jr.	1992-1999
Yank D. Coble	1994-2001	Robert E. McAfee	1984-1993	Steven J. Stack	2006-2014
David S. Cockrum	1993-1994	Barbara L. McAneny	2010-2017	Michael Suk	1994-1995
MaryAnn Contogiannis	1989-1993	William A. McDade	2016-2020	Andrew M. Thomas	1997-1999
Malini Daniel	2012-2013	Mary Anne McCaffree	2008-2016	Jeffrey A. Towson	1998-1999
Christopher M. DeRienzo	2006-2008	Joe T. McDonald	2005-2006	Georgia A. Tuttle	2011-2019
Nancy W. Dickey	1989-1997	Samuel J. Mackenzie	2014-2015	Jordan M. VanLare	2011-2012
Alexander Ding	2011-2013	Robert R. McMillan	2002-2008	Robert M. Wah	2005-2013
William A. Dolan	2007-2011	Sandeep "Sunny" Mistry	2000-2001	Peter Y. Watson	2001-2003
Timothy T. Flaherty	1994-2003	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996
Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019		

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates but are representatives of the following societies which are represented in the SSS.)

Academy of Consultation Liaison Psychiatry	Lee Tynes, MD
American Academy of Addiction Psychiatry	Alena Balasanova, MD
American Academy of Emergency Medicine	Joseph Wood, MD, JD
American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American College of Lifestyle Medicine	Cate Collings, MD
American Epilepsy Society	David M. Labiner, MD
American Society for Aesthetic Plastic Surgery	Clark F. Schierle, MD
American Society for Laser Medicine and Surgery	George Hruza, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Venous Forum	Eleftherios Xenos, MD
Association of Academic Physiatrists	Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Gary Pushkin, MD
Korean American Medical Association	John Yun, MD
Society for Cardiovascular Magnetic Resonance	Edward T. Martin, MD
Society for Pediatric Dermatology	Dawn Davis, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - JUNE 2023

**The following is a list of delegates and alternate delegates to the House of Delegates
as reported to the Executive Vice President**

Medical Association of the State of Alabama

Delegate(s)

B Jerry Harrison, Haleyville AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

George C. Smith, Lineville AL

Alternate Delegate(s)

Alexis Mason, Tuscaloosa AL

Jane Weida, Tuscaloosa AL

Tom Weida, Tuscaloosa AL

Regional Medical Student Delegate(s)

Amber Shirley, New Tazewell TN

Regional Medical Student Alternate Delegate(s)

Joshua Collingwood, Dothan AL

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Rhene Merkouris, Anchorage AK

Arizona Medical Association

Delegate(s)

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Marc Leib, Phoenix AZ

Alternate Delegate(s)

Adam Brodsky, Phoenix AZ

Timothy Fagan, Tucson AZ

Jennifer Hartmark-Hill, Phoenix AZ

Arizona Medical Association

Alternate Delegate(s)

Jacquelyn Hoffman, Tucson AZ

Arkansas Medical Society

Delegate(s)

Amy Cahill, White Hall AR

Eugene Shelby, Little Rock AR

Alan Wilson, Monticello AR

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Daniel Zedek, Chapel Hill NC

Alternate Delegate(s)

Keagan H. Lee, Austin TX

Nirali M. Patel, Chicago IL

US Public Health Service

Delegate(s)

Josh Schier, Orlando FL

Alternate Delegate(s)

Elizabeth Davlantes, Atlanta GA

Veterans Affairs

Delegate(s)

Carolyn M. Clancy, Silver Spring MD

Academic Physicians Section

Delegate(s)

Alma B. Littles, Tallahassee FL

Alternate Delegate(s)

Gary Gaddis, St. Louis MO

Integrated Physician Practice Section

Delegate(s)

Steven Wang, Bakersfield CA

Alternate Delegate(s)

Russell C. Libby, Fairfax VA

International Medical Graduates Section

Delegate(s)

Afifa Adiba, Wallingford CT

Alternate Delegate(s)

Natalia Solenkova, Aventura FL

Medical Student Section

Delegate(s)

Ryan Englander, Farmington CT

Alternate Delegate(s)

Brittany Ikwuagwu, Houston TX

Minority Affairs Section

Delegate(s)

Luis Seija, New York NY

Alternate Delegate(s)

Siobhan Wescott, Omaha NE

Organized Medical Staff Section

Delegate(s)

Matthew Gold, Winchester MA

Alternate Delegate(s)

Nancy Fan, Wilmington DE

Private Practice Physician Section

Delegate(s)

Timothy G. Mc Avoy, Waukesha WI

Alternate Delegate(s)

Daniel Eunsuk Choi, New Hyde Park NY

Resident and Fellow Section

Delegate(s)

Daniel Pfeifle, Rochester MN

Alternate Delegate(s)

Christopher T. Clifford, New York NY

Senior Physicians Section

Delegate(s)

Virginia E. Hall, Hummelstown PA

Alternate Delegate(s)

Douglas M. DeLong, Cherry Valley NY

Women Physicians Section

Delegate(s)

Nicole L. Plenty, Katy TX

Alternate Delegate(s)

Anna Brown, Howard WI

Young Physicians Section

Delegate(s)

Alisha Reiss, Greenville OH

Alternate Delegate(s)

Sean Figy, Omaha NE

**Reference Committee Hearing Room Assignments
Saturday, June 10**

1:30pm

Room

Amendments to Constitution & Bylaws	Grand Hall K/L
A Medical Service	Grand Hall I/J
B Legislative advocacy	Regency Ballroom A/B
C Advocacy on medical education	Regency Ballroom C/D
D Public Health	Riverside East
F AMA governance and finance	Grand Ballroom

**Reference Committee Hearing Room Assignments
Sunday, June 11**

8:00am

Room

E Science and Technology	Grand Ballroom
G Medical Practice	Grand Hall K/L

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

2023 Annual Meeting Notes on Orders of Business Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 9, 6:00 – 8:00 pm

SECOND SESSION, Saturday, June 10, 12:30 – 1:00 pm

THIRD SESSION, Monday, June 12, 1:00 – 6:00 pm

FOURTH SESSION, Tuesday, June 13, 9 am (or 10 minutes after Election Session) – 3:00 pm

Note: The Inauguration of Jesse M. Ehrenfeld, MD, MPH, as the 178th President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.

FIFTH SESSION, Wednesday, June 14, 8:30 am – completion of business

SUMMARY OF FISCAL NOTES (A-23)

BOT Report(s)

- 01 Annual Report: none
- 02 New Specialty Organizations Representation in the House of Delegates: Minimal
- 03 2022 Grants and Donations: Informational report
- 04 AMA 2024 Dues: none
- 05 Update on Corporate Relationships: Informational report
- 06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
- 07 AMA Performance, Activities, and Status in 2022: Informational report
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023: Informational report
- 09 Council on Legislation Sunset Review of 2013 House Policies: Modest
- 10 American Medical Association Health Equity Annual Report: Informational report
- 11 HPSA and MUA Designation For SNFs: Modest
- 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners: Minimal
- 13 Delegate Apportionment and Pending Members: Minimal
- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations: \$274,962
- 15 National Cancer Research Patient Identifier: Minimal
- 16 Informal Inter-Member Mentoring: Informational report
- 17 AMA Public Health Strategy: --
- 18 Making AMA Meetings Accessible: none
- 19 Medical Community Voting in Federal and State Elections: Informational report
- 20 Surveillance Management System for Organized Medicine Policies and Reports: --

CC&B Report(s)

- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update: Minimal

CEJA Opinion(s)

- 01 Amendment to Opinion 4.2.7, "Abortion": Informational report
- 02 Amendment to Opinion E-10.8, "Collaborative Care": Informational report
- 03 Pandemic Ethics and the Duty of Care: Informational report

CEJA Report(s)

- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions: Minimal
- 02 Ethical Principles for Physicians In Private Equity Owned Practices: Minimal
- 03 Short-term Medical Service Trips: Minimal
- 04 Responsibilities to Promote Equitable Care: Minimal
- 05 CEJA's Sunset Review of 2013 House Policies: Minimal
- 06 Use of De-identified Patient Information D-315.969: Informational Report
- 07 Use of Social Media for Product Promotion and Compensation: Informational report
- 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report: Informational report

CLRPD Report(s)

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership: Informational report

SUMMARY OF FISCAL NOTES (A-23)

CLRPD Report(s)

- 02 A Primer on the Medical Supply Chain: Informational report

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies: Minimal
- 02 Financing Medical Education: Minimal
- 03 Financial Burdens and Exam Fees for International Medical Graduates: Minimal
- 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance: Not yet determined
- 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Not yet determined
- 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants: Minimal
- 07 Management and Leadership Training in Medical Education: Minimal
- 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict: Minimal
- 09 The Impact of Midlevel Providers on Medical Education: Minimal

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2013 House Policies: Minimal
- 02 Medicare Coverage of Dental, Vision, and Hearing Services: Minimal
- 03 Private Insurer Payment Integrity: Minimal
- 04 Bundled Payments and Medically Necessary Care: Minimal
- 05 Prescription Drug Dispensing Policies: Minimal
- 06 Health Care Marketplace Plan Selection: Informational report
- 07 Reporting Multiple Services Performed During a Single Patient Encounter: Minimal
- 08 Impact of Integration and Consolidation on Patients and Physicians: Minimal
- 09 Federally Qualified Health Centers and Rural Health Care: Minimal

CSAPH Report(s)

- 01 Oppose Scheduling of Gabapentin: Minimal
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices: Minimal
- 03 Regulation and Control of Self-Service Labs: Minimal
- 04 School Resource Officer Violence De-Escalation Training and Certification: Minimal
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers: Minimal
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections: Minimal
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders: Minimal
- 08 Sunset Review of 2013 HOD Policies: Minimal

HOD Comm on Compensation of the Officers

- 01 Report of the HOD Committee on the Compensation of the Officers: \$0

Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 001 Opposing Mandated Reporting of LGBTQ+ Status: Minimal
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports: Minimal
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation: Modest
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research": Minimal
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees: Minimalo
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare: Modest
- 007 Independent Medical Evaluation: Modest
- 101 Updating Physician Job Description for Disability Insurance: Not yet determined
- 102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use: Modest
- 103 Movement Away from Employer-Sponsored Health Insurance: Minimal
- 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment: minimal
- 105 Studying Population-Based Payment Policy Disparities: Modest
- 106 Billing for Traditional Healing Services: Modest
- 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use: Modest
- 108 Sustainable Reimbursement for Community Practices: Modest
- 109 Improved Access to Care For Patients in Custody of Protective Services: Modest
- 110 Long-Term Care Coverage for Dementia Patients: Modest
- 201 Pharmacists Prescribing for Urinary Tract Infections: Modest
- 202 Support for Mental Health Courts: Minimal
- 203 Drug Policy Reform: Modest
- 204 Supporting Harm Reduction: Modest
- 205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness: Minimal
- 206 Tribal Public Health Authority: Modest
- 207 Ground Ambulance Services and Surprise Billing: Minimal
- 208 Medicaid Managed Care for Indian Health Care Providers: Modest
- 209 Purchased and Referred Care Expansion: Modest
- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border: Minimal
- 211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits: Minimal
- 212 Marijuana Product Safety: Modest
- 213 Telemedicine Services and Health Equity: Resolve 1 Modest. Resolve 2 Minimal.
- 214 Advocacy and Action for a Sustainable Medical Care System: Modest
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud: Minimal
- 216 Improved Foster Care Services for Children: Modest
- 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools: Minimal
- 218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners: Moderate
- 219 Repealing the Ban on Physician-Owned Hospitals: Modest
- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations: Modest
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool: Minimal
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA): Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 223 Protecting Access to Gender Affirming Care: Modest
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers: Modest
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
- 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations: Modest
- 303 Medical School Management of Unmatched Medical Students: Moderate
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement: Modest
- 305 Indian Health Service Graduate Medical Education: Minimal
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students: Moderate
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents: Minimal
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants: Minimal
- 309 Against Legacy Preferences as a Factor in Medical School Admissions: Modest
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation: Modest
- 311 Residency Application Support for Students of Low-Income Backgrounds: Minimal
- 312 Indian Health Service Licensing Exemptions: Modest
- 313 Filtering International Medical Graduates During Residency or Fellowship Applications: Modest
- 314 Support for International Medical Graduates from Turkey: Modest
- 401 Metered Dose Inhalers and Greenhouse Gas Emissions: Modest
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance: Minimal
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers: Modest
- 405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court: Minimal
- 406 Increase Employment Services Funding for People with Disabilities: Minimal
- 407 Addressing Inequity in Onsite Wastewater Treatment: Minimal
- 408 School-to-Prison Pipeline: Minimal
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training: Modest
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs: Minimal
- 411 Protecting Workers During Catastrophes: Modest
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal: Minimal
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population: Minimal
- 415 Environmental Health Equity in Federally Subsidized Housing: Modest
- 416 New Policies to Respond to the Gun Violence Public Health Crisis: Modest
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health: Moderate
- 418 Increasing the Availability of Automated External Defibrillators: Minimal
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System: Minimal
- 420 Foster Health Care: Minimal
- 421 Prescribing Guided Physical Activity for Depression and Anxiety: Modest
- 422 National Emergency for Children: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 423 Reducing Sodium Intake to Improve Public Health: Not yet determined
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home: Minimal
- 501 AMA Study of Chemical Castration in Incarceration: Modest
- 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures: Minimal
- 503 Increasing Diversity in Stem Cell Biobanks and Disease Models: Minimal
- 504 Regulating Misleading AI Generated Advice to Patients: Modest
- 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations: Minimal
- 506 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development: Approximately \$47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.
- 507 Recognizing the Burden of Rare Disease: Minimal
- 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses: Minimal
- 509 Addressing Medical Misinformation Online: Minimal
- 510 Comparative Effectiveness Research: Modest
- 511 Regulation of Phthalates in Adult Personal Sexual Products: Minimal
- 512 Wheelchairs on Airplanes: Minimal
- 513 Substance Use History is Medical History: Minimal
- 514 Adolescent Hallucinogen-Assisted Therapy Policy: Moderate
- 515 Regulate Kratom and Ban Over-The-Counter Sales: Minimal
- 516 Fasting is Not Required for Lipid Analysis: Approximately \$50k for the development of CME-accredited interactive e-learning including staff costs and external vendor contracting
- 601 Solicitation using the AMA Brand: Minimal
- 602 Supporting the Use of Gender-Neutral Language: Up to \$23K to review all current AMA policies and compile a report with recommendations for HOD consideration
- 603 Environmental Sustainability of AMA National Meetings: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of car
- 604 Speakers Task Force to Review and Modernize the Resolution Process: Modest
- 605 Equity and Justice Initiatives for International Medical Graduates: Approximately \$44K for a one-time update of the health equity strategic plan, plus ~\$24k annually to produce the requested forum
- 701 Reconsideration of the Birthday Rule: Minimal
- 702 Providing Reduced Parking for Patients: Minimal
- 703 Tribal Health Program Electronic Health Record Modernization: Minimal
- 704 Interrupted Patient Sleep: Minimal
- 705 Aging and Dementia Friendly Health Systems: Modest
- 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis: Not yet determined
- 707 Expediting Repairs for Power and Manual Wheelchairs: Modest
- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures: Modest
- 709 Hospital Bans on Trial of Labor After Cesarean: Not yet determined

SUMMARY OF FISCAL NOTES (A-23)

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

RESOLUTIONS - BY SPONSOR (A-23)

American Academy of Child and Adolescent Psychiatry

- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare
 - 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
 - 421 Prescribing Guided Physical Activity for Depression and Anxiety
 - 422 National Emergency for Children
 - 513 Substance Use History is Medical History
 - 514 Adolescent Hallucinogen-Assisted Therapy Policy
-

American Academy of Pediatrics

- 109 Improved Access to Care For Patients in Custody of Protective Services
 - 216 Improved Foster Care Services for Children
 - 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
 - 420 Foster Health Care
 - 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
-

American Academy of Physical Medicine and Rehabilitation

- 512 Wheelchairs on Airplanes
 - 604 Speakers Task Force to Review and Modernize the Resolution Process
 - 707 Expediting Repairs for Power and Manual Wheelchairs
-

American Association of Clinical Urologists

- 201 Pharmacists Prescribing for Urinary Tract Infections
-

American College of Gastroenterology

- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures
-

American Society for Metabolic and Bariatric Surgery

- 224 Advocacy Against Obesity-Related Bias by Insurance Providers
-

American Society for Surgery of the Hand

- 504 Regulating Misleading AI Generated Advice to Patients
-

District of Columbia

- 108 Sustainable Reimbursement for Community Practices
-

Endocrine Society

- 223 Protecting Access to Gender Affirming Care
-

International Medical Graduates Section

- 313 Filtering International Medical Graduates During Residency or Fellowship Applications
- 314 Support for International Medical Graduates from Turkey
- 605 Equity and Justice Initiatives for International Medical Graduates

Medical Student Section

- 001 Opposing Mandated Reporting of LGBTQ+ Status
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
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- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border
- 211 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
- 305 Indian Health Service Graduate Medical Education
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
- 309 Against Legacy Preferences as a Factor in Medical School Admissions
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- 312 Indian Health Service Licensing Exemptions
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court
- 406 Increase Employment Services Funding for People with Disabilities
- 407 Addressing Inequity in Onsite Wastewater Treatment
- 408 School-to-Prison Pipeline
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
 - 411 Protecting Workers During Catastrophes
 - 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
 - 413 Supporting Intimate Partner and Sexual Violence Safe Leave
 - 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
 - 415 Environmental Health Equity in Federally Subsidized Housing
 - 416 New Policies to Respond to the Gun Violence Public Health Crisis
 - 418 Increasing the Availability of Automated External Defibrillators
 - 501 AMA Study of Chemical Castration in Incarceration
 - 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
 - 503 Increasing Diversity in Stem Cell Biobanks and Disease Models
 - 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
 - 506 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
 - 507 Recognizing the Burden of Rare Disease
 - 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
 - 509 Addressing Medical Misinformation Online
 - 510 Comparative Effectiveness Research
 - 511 Regulation of Phthalates in Adult Personal Sexual Products
 - 602 Supporting the Use of Gender-Neutral Language
 - 603 Environmental Sustainability of AMA National Meetings
 - 701 Reconsideration of the Birthday Rule
 - 702 Providing Reduced Parking for Patients
 - 703 Tribal Health Program Electronic Health Record Modernization
 - 704 Interrupted Patient Sleep
 - 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
 - 709 Hospital Bans on Trial of Labor After Cesarean
-

Mississippi

- 110 Long-Term Care Coverage for Dementia Patients
 - 218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
 - 219 Repealing the Ban on Physician-Owned Hospitals
 - 515 Regulate Kratom and Ban Over-The-Counter Sales
-

New England

- 007 Independent Medical Evaluation
 - 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
 - 423 Reducing Sodium Intake to Improve Public Health
-

Oklahoma

- 212 Marijuana Product Safety

Pennsylvania

- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool
 - 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
-

Resident and Fellow Section

- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
 - 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations
 - 303 Medical School Management of Unmatched Medical Students
 - 601 Solicitation using the AMA Brand
-

Senior Physicians Section

- 213 Telemedicine Services and Health Equity
 - 214 Advocacy and Action for a Sustainable Medical Care System
 - 417 Treating Social Isolation and Loneliness as a Social Driver of Health
 - 516 Fasting is Not Required for Lipid Analysis
 - 705 Aging and Dementia Friendly Health Systems
-

Washington

- 401 Metered Dose Inhalers and Greenhouse Gas Emissions
-

Young Physicians Section

- 101 Updating Physician Job Description for Disability Insurance
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

** contained in the Handbook Addendum*

contained in the Sunday Tote

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 02 New Specialty Organizations Representation in the House of Delegates
- 15 National Cancer Research Patient Identifier

CC&B Report(s)

- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update

CEJA Report(s)

- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
- 02 Ethical Principles for Physicians In Private Equity Owned Practices
- 03 Short-term Medical Service Trips
- 04 Responsibilities to Promote Equitable Care
- 05 CEJA's Sunset Review of 2013 House Policies

Resolution(s)

- 001 Opposing Mandated Reporting of LGBTQ+ Status
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare
- 007 Independent Medical Evaluation

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-23

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the
2 applications of the American Academy of Addiction Psychiatry, American Society for Aesthetic
3 Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance for national medical
4 specialty organization representation in the American Medical Association (AMA) House of
5 Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and
6 presented to the SSS Assembly for consideration.
7

8 The applications were considered using criteria developed by the Council on Long Range Planning
9 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)
10

11 Organizations seeking admission were asked to provide appropriate membership information to the
12 AMA. That information was analyzed to determine AMA membership, as required under criterion
13 three. A summary of this information is attached to this report as Exhibit B.
14

15 In addition, organizations must submit a letter of application in a designated format. This format
16 lists the above-mentioned guidelines followed by each organization's explanation of how it meets
17 each of the criteria.
18

19 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.
20 These organizations have actively participated in the SSS for more than three years.
21

22 Review of the materials and discussion during the SSS meeting at the November 2022 Interim
23 Meeting indicated that the American Academy of Addiction Psychiatry, American Society for
24 Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance meet the criteria
25 for representation in the HOD.
26

27 **RECOMMENDATION**
28

29 Therefore, the Board of Trustees recommend that the American Academy of Addiction Psychiatry,
30 American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic
31 Resonance be granted representation in the AMA House of Delegates and that the remainder of the
32 report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX
Exhibit A

**GUIDELINES FOR REPRESENTATION IN & ADMISSION TO
THE HOUSE OF DELEGATES:**

National Medical Specialty Societies

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

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Addiction Psychiatry	384 of 1,127 (34%)
American Society for Aesthetic Plastic Surgery	359 of 1,691 (21%)
Society for Cardiovascular Magnetic Resonance	254 of 866 (30%)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-23

Subject: National Cancer Research Patient Identifier

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Resolution 021-A-22, “National Cancer Research Identifier,” sponsored by the Mississippi
2 Delegation, was referred by the House of Delegates. Resolution 021-A-22 asks our AMA to
3 establish:

4
5 “[The] National Cancer Research Identifier (NCRI) [...] to improve care for patients with
6 cancer.”

7
8 The NCRI as described would be overseen by a nonprofit entity, and the role of the NCRI would be
9 to collect identifying patient information to create:

10
11 “a privacy-ensuring, unique cancer research identifier [that] could travel with the anonymous
12 fragments of medical information currently collected by large databases, and therefore allow
13 the fragments to be reunited into a complete, yet anonymous cancer journey that researchers
14 can study to improve care”.

15
16 The summary of testimony from A-22 acknowledges concerns regarding the creation of the NCRI
17 and recommends Resolution 021 for referral. Testimony was strongly in support of referral, noting
18 the complexity of the issue, i.e., a national identifier may exclude some people from clinical trials,
19 may dissuade some people with privacy concerns from joining trials, may put undue burdens (e.g.,
20 further EHR responsibilities) on some physicians, and it may implicate privacy, trust, and
21 surveillance concerns. Testimony also noted concern about what organizations would be involved
22 in overseeing the NCRI process and questioned why the resolution should be limited to cancer
23 rather than be broader in scope.

24 25 BACKGROUND

26
27 In the US, all 50 states have laws that require newly diagnosed cancers to be reported to a central
28 cancer registry [1]. The CDC’s National Program of Cancer Registries (NPCR) and NCI’s
29 Surveillance, Epidemiology, and End Results (SEER) Program are the two primary central
30 registries that collect cancer incidence data in the US. Together, the NPCR and the SEER Program
31 collect data from the entire US population, and according to a 2017 joint report by the CDC and
32 NIH, the two comprehensive surveillance systems work collaboratively to collect, compile, and
33 disseminate information on more than 1.7 million cancer cases annually [2].

1 ALTERNATIVES TO NCRI

2
3 While Resolution 021-A-22 claims that the formation of the NCRI would “dramatically increase
4 the speed and power of real-world research” it is unclear if this would be the case. Using identified
5 data may in fact slow down the research process if the identified data are subject to the Common
6 Rule, which would require researchers using NCRI data to go through IRB approval. Furthermore,
7 as noted in BOT 16 N-21 “De-Identified Data” and Resolution 003-A-18 “Proposing Consent for
8 De-Identified Patient Information,” once data has been de-identified, HIPAA no longer applies,
9 which raises potential concerns if certain entities obtain access to the NCRI. This is particularly
10 troubling because of the unequal power between those whose data has been collected and those
11 who control that data, an issue that has been referred to as the “Big Data Divide” [3]. This is also a
12 threat to justice within clinical research, as data subjects from lower socioeconomic and/or
13 minority backgrounds tend to have even less control over their data and are thus more vulnerable to
14 misuse of their data [4].

15
16 Meanwhile current cancer research is clipping along at a steady pace. A 2020 report by Springer
17 Nature found that “[t]he number of cancer research articles published in journals listed in the
18 Nature Index increased by 25.8 percent between 2015 and 2019. This is four times the growth for
19 overall article output in this period” [5]. The report also found that the US’s National Cancer
20 Institute (NCI) “is by far the world’s biggest funder of cancer research” [5].

21
22 Supporting the NCRI’s data modernization efforts to move to modern cloud-based systems,
23 working to ensure that data collection is conducted in a just and equitable manner for all peoples,
24 and encouraging physicians to discuss opportunities with cancer patients about participating in
25 cancer research may be more appropriate avenues for our AMA to approach improving cancer
26 research instead of forming the NCRI.

27
28 Our AMA could also seek to promote data and code sharing in oncology research as an alternative
29 means of accomplishing the goal of Resolution 021. The practice of code sharing involves stating
30 explicitly, in text or supplementary material, in research publications if and where any or all data or
31 code underpinning the results is available for access. A recent research paper found that data and
32 code sharing occur infrequently in oncology despite the prevalence of mandatory sharing policies
33 outlined by publishers; additionally, there is a large gap between oncology researchers who declare
34 their data to be available, and those who actually archive data in a way that facilitates its reuse [6].

35
36 ETHICAL CONCERNS SURROUDING NCRI

37
38 The AMA’s *Code of Medical Ethics* does not explicitly prohibit such a patient identifier so long as
39 the body adheres to the Code’s opinions on protecting patient confidentiality, respecting patient
40 privacy, providing appropriate informed consent, and ensuring the data is used in a manner that
41 promotes justice (see [Opinion 3.2.1](#) Confidentiality; [Opinion 3.3.2](#) Confidentiality & Electronic
42 Medical Records; [Opinion 3.2.4](#) Access to Medical Records by Data Collection Companies;
43 [Opinion 4.1.3](#) Third-Party Access to Genetic Information; [Opinion 3.1.1](#) Privacy in Health Care;
44 [Opinion 7.3.7](#) Safeguards in the Use of DNA Databanks; [Opinion 2.1.1](#) Informed Consent; [Opinion](#)
45 [7.1.2](#) Informed Consent in Research; [Opinion 8.5](#) Disparities in Health Care).

46
47 However, Policy [H-315.962](#) “Research Handling of De-Identified Patent Information” states,
48 “[o]ur AMA supports efforts to promote transparency in the use of de-identified patent data and to
49 protect patient privacy by developing methods of, and technologies for, de-identification of patient
50 information that reduce the risk of re-identification of such information.” The collection and use of
51 identified patient data pose several concerns as even de-identified data do not eliminate the risk of

1 re-identification that can potentially harm patients. The Board observes the Council on Ethical and
2 Judicial Affairs is in the process of reviewing existing ethics guidance on the use of patient
3 information in research.

4

5 CONCLUSION

6

7 For these reasons, the Board concludes that the creation of a national cancer patient research
8 identifier is neither necessary nor desirable. AMA resources might be better utilized to support data
9 modernization efforts by existing cancer registries, work to ensure that no groups face barriers to
10 data collection efforts, encourage physicians to educate and engage patients to participate in
11 existing cancer research, and urge cancer researchers to improve data and code sharing.

12

13 RECOMENDATIONS

14

15 In light of these considerations, your Board of Trustees recommends that the following be adopted
16 in lieu of Resolution 021, A-22, "National Cancer Research Patient Identifier," and the remainder
17 of this report be filed:

18

19 Our AMA encourages greater use of code and data sharing to enhance the timely conduct of
20 research in oncology and implementation of innovations in care.

Fiscal Note: Minimal – less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-23

Subject: AMA Bylaws--Gender Neutral Language and Miscellaneous Update

Presented by: Kevin Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The AMA Constitution establishes the basic principles of our AMA and the AMA Bylaws provide
2 the framework for the governance and administration of the Association. Our AMA membership,
3 like the population of physicians practicing in the United States, has become increasingly diverse.
4 Language plays a major role in shaping culture and social attitudes and gender-neutral language
5 promotes gender equality and inclusivity and eradicates gender bias; thus, your Council believes
6 that the AMA Constitution and Bylaws should utilize gender-neutral language, and proposes
7 recommendations for Bylaw amendments for House consideration and action.

8
9 The *Merriam-Webster Dictionary* recognizes the word ‘they’ as a singular pronoun, and the *AP*
10 *Manual of Style* states that “they/them/their is acceptable in limited cases as a singular and-or
11 gender-neutral pronoun, when alternative wording is overly awkward or clumsy.” Lastly, the *AMA*
12 *Manual of Style* provides the following guidance: “Avoid sex-specific pronouns in cases in which
13 sex specificity is irrelevant. Do not use common-gender “pronouns” (eg, “s/he,” “shem,” “shim”).
14 Reword the sentence to use a singular or plural non–sex-specific pronoun, neutral noun equivalent,
15 or change of voice; or use “he or she” (“him or her,” “his or her[s],” “they or their[s]”). The use of
16 the “singular they” construction is permitted when rewriting would be awkward or unclear.”

17
18 It also should be noted that where Bylaw language is included in the Internal Operating Procedures
19 (IOPs) of an AMA section or in the Rules of an AMA Council, those documents will be similarly
20 modified. All sections are or will be modifying their IOPs to make these gender-neutral.

21
22 Lastly, there is one other proposed change unrelated to gender-neutrality in 7.4.1, which defines the
23 membership of the Organized Medical Staff Section (OMSS). The change in wording from “Active
24 resident and fellows who have been ~~selected~~ certified by their medical staffs as representatives to
25 the Business Meeting also shall be considered members of the Section,” mirrors the language in the
26 OMSS IOPs and accurately reflects OMSS practice.

27 28 RECOMMENDATIONS

29
30 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
31 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative
32 vote of two-thirds of the members of the House of Delegates present and voting.

1 **2—House of Delegates**

2
3 ****

4
5 **2.8 Alternate Delegates.**

6
7 ***

8
9 **2.8.6 Status.** The alternate delegate is not a “member of the House of Delegates” as that
10 term is used in these Bylaws. Accordingly, an alternate delegate may not introduce
11 resolutions into the House of Delegates, nor vote in any election conducted by the House
12 of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or
13 Vice Speaker of the House of Delegates. The alternate delegate must immediately
14 relinquish ~~his or her~~ their position on the floor of the House of Delegates upon the request
15 of the delegate for whom the alternate delegate is substituting.
16

17 **3—Officers**

18
19 ***

20
21 **3.4 Elections.**

22
23 ***

24 **3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee shall be listed
25 alphabetically on a single ballot. Each elector shall have as many votes as the number of
26 Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall
27 be counted if it contains fewer or more votes than the number of Trustees to be elected, or
28 if the ballot contains more than one vote for any nominee. A nominee shall be elected if
29 they ~~he or she~~ ~~has~~ have received a vote on a majority of the legal ballots cast and is ~~are~~ one
30 of the nominees receiving the largest number of votes within the number of Trustees to be
31 elected.
32

33
34 ***

35 **3.5 Terms and Tenure.**

36
37 ***

38
39 **3.5.7.1 Limitations.** No candidate shall be eligible for election or re-election as the young
40 physician trustee unless, at the time of election, ~~he or she is~~ they are under 40 years of age
41 or within the first eight years of practice after residency and fellowship training, and ~~is~~ are
42 not a resident/fellow physician. A young physician trustee shall be eligible to serve on the
43 Board of Trustees for the full term for which elected, even if during that term the trustee
44 reaches 40 years of age or completes the eighth year of practice after residency and
45 fellowship training.
46

47
48 ***

49 **3.8 Installation of Officers.** The officers of the AMA shall assume their duties at the close of
50 the meeting at which they are elected, except as stated herein. The medical student trustee shall
51 assume office at the close of the Annual Meeting following the Interim Meeting at which the

1 medical student trustee was elected. If elected at an Interim Meeting or Special Meeting, the
2 public trustee shall assume office at the close of the Annual Meeting following ~~his or her~~ their
3 election. If elected at an Annual Meeting, the public trustee shall assume office at the close of
4 the Annual Meeting at which ~~he or she~~ was elected.

5
6 **6—Councils**

7
8 ***

9
10 **6.8 Election - Council on Constitution and Bylaws, Council on Medical Education,**
11 **Council on Medical Service, and Council on Science and Public Health.**

12
13 ***

14
15 **6.8.1.2 Other Council Members.** With reference to each such Council, all nominees for
16 election shall be listed alphabetically on a single ballot. Each elector shall have as many
17 votes as there are members to be elected, and each vote must be cast for a different
18 nominee. No ballot shall be counted if it contains fewer votes or more votes than the
19 number of members to be elected, or if the ballot contains more than one vote for any
20 nominee. A nominee shall be elected if ~~he or she~~ they have ~~has~~ received a vote on a
21 majority of the legal ballots cast and ~~is~~ are one of the nominees receiving the largest
22 number of votes within the number of members to be elected.

23
24 **7—Sections**

25
26 ***

27
28 **7.4 Organized Medical Staff Section.**

29
30 **7.4.1 Membership.** Membership in the Section shall be open to all active physician
31 members of the AMA who are members of a medical staff of a hospital or a
32 medical staff of a group of practicing physicians organized to provide healthcare.
33 Active resident and fellow members of the AMA who are ~~selected~~ certified by their
34 medical staffs as representatives to the Business Meeting also shall be considered
35 members of the Section.

36
37 ***

38
39 **7.4.2 Representatives to the Business Meeting.** Each medical staff of a hospital and each
40 medical staff of a group of practicing physicians organized to provide healthcare may
41 select up to two active physician AMA member representatives to the Business Meeting.
42 The president or chief of staff of a medical staff may also attend the Business Meeting as a
43 representative if ~~he or she is~~ they are an active physician member of the AMA. The
44 representatives must be physician members of the medical staff of a hospital or group of
45 practicing physicians organized to provide healthcare or residents/fellows affiliated with
46 the medical staff of a hospital or group of practicing physicians organized to provide
47 healthcare. All representatives to the Business Meeting shall be properly certified in
48 accordance with procedures established by the Governing Council and approved by the
49 Board of Trustees.

1 **7.4.2.1** When a multi-hospital system and its component medical staffs have unified
2 the medical staffs, those medical staff members who hold specific privileges to practice
3 at each separate entity within the unified system may select up to two representatives
4 to the Business Meeting, so long as they are active physician members of the AMA.
5 The president or chief of staff of a unified medical staff also may attend the Business
6 Meeting as a representative if ~~he or she is~~ they are an active physician member of the
7 AMA.

8
9 ***

10
11 **7.7 Minority Affairs Section.**

12
13 ***

14
15 **7.7.3.1 Section Representatives on the Governing Council.** If a representative of the
16 Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases
17 to meet the criteria for membership in the section from which elected within 90 days prior
18 to the Annual Meeting, such member shall be permitted to serve in office until the
19 conclusion of the Annual Meeting in the calendar year in which ~~he or she~~ they ceases to
20 meet the membership requirement of the respective section.

21
22 **7.7.3.2 Section Representative as Immediate Past Chair.** A Section representative who
23 has been elected as chair of the Governing Council, but who ceases to meet the criteria for
24 membership in the section from which elected during ~~his or her~~ their term as Immediate
25 Past Chair, shall be permitted to complete the term of office, as long as the officer remains
26 an active physician member of the AMA.

27
28 ***

29
30 **7.10 Women Physicians Section.**

31
32 ***

33
34 **7.10.3.1 Section Representatives on the Governing Council.** If a representative of the
35 Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases
36 to meet the criteria for membership in the section from which elected within 90 days prior
37 to the Annual Meeting, such member shall be permitted to serve in office until the
38 conclusion of the Annual Meeting in the calendar year in which ~~she or he~~ they ceases to
39 meet the membership requirement of the respective section.

40
41 (Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-23

Subject: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy [D-320.977](#), “Utilization Review, Medical Necessity Determination, Prior Authorization
2 Decisions,” as adopted in June 2022, requests that the Council on Ethical and Judicial Affairs
3 “review current ethical opinions similar to the Texas Medical Association (TMA) Board of
4 Councilors’ opinions regarding medical necessity determination and utilization review.”

5
6 The relevant [TMA Board of Councilors](#) opinions read as follows:

7
8 MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine;
9 it is not a benefit determination. Whether or not a proposed treatment is medically necessary
10 should be decided in a manner consistent with generally accepted standards of medical practice
11 that a prudent physician would provide to a patient for the purposes of preventing, diagnosing
12 or treating an illness, injury, disease or its symptoms. This is true even if the physician making
13 the medical necessity determination is making those decisions on behalf of a managed care
14 organization. That physician must not permit financial mechanisms to interfere with his/her
15 determination as to whether a treatment is medically necessary. Although the physician may
16 take cost considerations into account, the physician may not refuse to approve the medical
17 necessity of a treatment simply based on cost, and must approve the treatment if it is clearly
18 more therapeutically effective than other treatment options that may be covered under the plan,
19 even if those treatment options are less expensive than their more costly counterpart.

20
21 UTILIZATION REVIEW. The physician who performs prospective and/or concurrent
22 utilization review is obligated to review the request for treatment with the same standard of
23 care as would be required by the profession in the community in which the patient is being
24 treated.

25
26 As originally presented to the American Medical Association (AMA) House of Delegates, the
27 background resolution asked that Council on Ethical and Judicial Affairs (CEJA) “devise ethical
28 opinions similar to” those issued by the TMA Board of Councilors (Resolution 727 A-22).

29
30 The opinions of the TMA maintain that decisions about the appropriateness of recommended
31 interventions are matters of professional medical judgment, not administrative determinations.

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

1 Thus, physicians charged to determine whether an intervention is medically necessary on behalf of
2 health care organizations or third-party payers

- 3
- 4 • may not refuse to approve treatment based solely on cost considerations; and
- 5 • must approve treatment that is “clearly more therapeutically effective” even if it is costlier
- 6 than other covered options.
- 7

8 Physicians who perform utilization review likewise should base determinations on the standard of
9 care prevailing in the professional community.

10
11 The council reviewed existing guidance in the AMA *Code of Medical Ethics* and concluded that
12 issues raised by the opinions of the TMA are appropriately addressed in several opinions:

- 13
- 14 • 10.1 [“Ethics Guidance for Physicians in Nonclinical Roles”](#)
- 15 • 10.1.1 [“Ethical Obligations of Medical Directors”](#)
- 16 • 11.2.1 [“Professionalism in Health Care Systems”](#)
- 17 • 11.2.2 [“Conflicts of Interest in Patient Care”](#)
- 18 • 11.2.3 [“Contracts to Deliver Health Care Services”](#)
- 19 • 11.2.6 [“Mergers of Secular and Religiously Affiliated Health Care Institutions”](#)
- 20 • 11.1.2 [“Physician Stewardship of Health Care Resources”](#)
- 21

22 Opinions 10.1 and 10.1.1 maintain that whenever physicians “use the knowledge and values they
23 gained through medical training . . . in roles that affect the care and well-being” of patients,
24 physicians are “functioning within the sphere of their profession” and must uphold their fiduciary
25 obligations to patients. Opinion 11.2.2 holds patient welfare takes priority over the economic
26 interests of hospitals, health care organizations, and other entities.

27
28 Opinion 11.2.1 sets out essential conditions for the ethically appropriate design and use of
29 incentives to address health care costs. Rather than address specific mechanisms or strategies,
30 guidance identifies key ethics concerns, particularly conflict of interest and implications for
31 physicians’ exercise of professional judgment and professionalism. Thus 11.2.1 defines essential
32 conditions for the ethical use of incentives, irrespective of the form such incentives may take:

- 33
- 34 • ensuring that health care disparities are not exacerbated
- 35 • ensuring that supporting infrastructure and resources are in place to support high quality
- 36 care and physician professionalism
- 37 • recognizing and respecting physicians’ duty to advocate on behalf of patients by providing
- 38 meaningful pathways for appealing denials of care
- 39 • accepting an institutional obligation to monitor the impact of incentives
- 40

41 Although it speaks less directly to matters of determining medical necessity or utilization review,
42 Opinion 11.2.6 similarly underscores the importance of ensuring that health care institutions adopt
43 mechanisms to enable physicians to appeal constraints in order to meet the unique needs of
44 individual patients and to monitor the impact of policies that constrain resource use or the
45 availability of clinical services.

46
47 Finally, Opinion 11.1.2 addresses the position expressed by the TMA that physicians should
48 approve “clearly more therapeutically effective” among available options, irrespective of cost.
49 11.1.2 provides that physicians should recommend interventions “demonstrated to meaningfully
50 improve clinical outcomes,” although when different interventions offer comparable benefits and
51 risks for an individual patient, they should generally prefer those that require fewer resources.

1 The council further noted that amending guidance specifically to address determinations of medical
2 necessity and utilization review as such would not be consistent with the approach taken in
3 modernizing the *Code of Medical Ethics*. In updating the *Code* CEJA intentionally reframed
4 guidance to ensure that it remained “evergreen” and not tied to specific technologies or practices.
5 The council focused on clarifying the ethical values underlying guidance and for the most part
6 eliminated specific examples and content that read as instruction on how to implement guidance.

7
8 Multiple opinions in earlier editions of the *Code* spoke to particulars of, e.g., capitation, use of
9 restricted medication formularies, and similar issues tied to strategies for cost containment imposed
10 by managed care organizations. In modernizing this guidance CEJA re-organized and consolidated
11 content from multiple opinions to focus on relevant ethics issues, such as conflict of interest and
12 physician professionalism. For example, Opinion 11.2.1, “Professionalism in Health Care
13 Systems,” identifies and consolidates guidance from five separate opinions to offer a succinct
14 statement of conditions essential to promoting professionalism in care delivery systems.

15
16 For these reasons, the council concluded that in its present form the *AMA Code of Medical Ethics*
17 appropriately addresses the fundamental concerns identified in the cited opinions of the TMA
18 Board of Councilors.

19
20 RECOMMENDATION

21
22 Based on the foregoing considerations, the Council on Ethical and Judicial Affairs recommends
23 that paragraph 2 of D-320.977, “Utilization Review, Medical Necessity Determination, Prior
24 Authorization Decisions,” be rescinded as having been accomplished and the remainder of this
25 report be filed:

26
27 1. Our AMA will advocate: (a) for implementation of a federal version of a prior authorization
28 “gold card” law, which aims to curb onerous prior authorization practices by many state-
29 regulated health insurers and health maintenance organizations; and (b) that health plans should
30 offer physicians at least one physician-driven, clinically-based alternative to prior
31 authorization, including a “gold-card” or “preferred provider program.”

32
33 ~~2. Our AMA will request that the Council on Ethical and Judicial Affairs review current~~
34 ~~ethical opinions similar to the Texas Medical Association Board of Councilors opinions~~
35 ~~regarding medical necessity determination and utilization review.~~

36
37 (Modify HOD policy)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-23

Subject: Ethical Principles for Physicians Involved in Private Equity Owned Practices

Presented by: Peter A Schwartz, MD, Chair MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 [Policy D-140.951](#), “Establishing Ethical Principles for Physicians Involved in Private Equity
2 Owned Practices,” instructs our American Medical Association (AMA) to

3
4 study and clarify the ethical challenges and considerations regarding physician
5 professionalism raised by the advent and expansion of private equity ownership or
6 management of physician practices and report back on the status of any ethical dimensions
7 inherent in these arrangements, including consideration of the need for ethical guidelines as
8 appropriate. Such a study should evaluate the impact of private equity ownership,
9 including but not limited to the effect on the professional responsibilities and ethical
10 priorities for physician practices.

11
12 This report presents the fruits of deliberations by the Council on Ethical and Judicial Affairs
13 (CEJA) on the need for ethics guidance in this area.

14
15 The council noted that current guidance in the AMA *Code of Medical Ethics (Code)* was developed
16 initially to address issues raised by the advent of managed care. Reflecting on the respective
17 challenges posed by managed care and private equity, the council concluded that where managed
18 care organizations focused on goals of cost-containment and improving efficiency of care delivery
19 rather than profitability per se, private equity/venture capital (PE/VC) investment in health care
20 practices explicitly aims to enhance the profitability of any medical practice in which they invest
21 during the period of their investment and further to realize significant profit when they divest of
22 that practice after a term of years.

23
24 CEJA observed that House policy adopted in 2019 substantially accomplishes the goals sought by
25 D-140.951. Council on Medical Service Report 11-A-19 carefully reviewed available data on the
26 scope and impact of PE/VC investment in health care. Its recommendations were adopted as [H-](#)
27 [160.891](#), “Corporate Investors,” which delineates 11 factors physicians should consider before
28 entering into partnership with corporate investors, including issues of alignment of mission, vision,
29 and goals; the degree to which corporate partners may require physicians to cede control over
30 practice decision making; process for staff representation on the board of directors and medical
31 leadership selection; and retaining medical authority in patient care and supervision of
32 nonphysician practitioners.

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

1 The AMA further developed and published materials to assist physicians contemplating partnering
2 with PE/VC firms:

- 3
- 4 • [Venture Capital and Private Equity: How to Evaluate Contractual Agreements](#)
- 5 • [Model Checklist: Venture Capital and Private Equity Investments](#)
- 6 • [Snapshot: Venture Capital and Private Equity Investments](#)
- 7

8 In the council’s view, the salient concerns raised by the engagement of PE/VC firms in health care,
9 notably challenges to physicians’ freedom to exercise professional judgment and strategies for
10 reducing cost/enhancing profitability, are addressed in existing guidance in Opinions [11.2.1](#),
11 “Professionalism in Health Care Systems”; [11.2.2](#), “Conflicts of Interest in Patient Care”; and
12 [11.2.3](#), “Contracts to Deliver Health Care Services.”

13

14 Given the existence of rich House policy on point and the fact that existing opinions in the *Code*
15 substantially address key issues of concern, the council concluded that guidance specifically
16 addressing PE/VC in health care is not the most effective response. Rather, the council believes
17 that amending current guidance to more clearly encompass partnerships with PE/VC firms would
18 best serve the interests of physicians and the patients they care for.

19

20 RECOMMENDATION

21

22 In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that
23 Opinion 11.2.3, “Contracts to Deliver Health Care Services,” be amended as follows and the
24 remainder of this report be filed:

25

26 Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other
27 considerations, including personal financial interests. This obligation requires ~~them to that~~
28 before entering into contracts to deliver health care services physicians consider carefully the
29 proposed contract to assure themselves that the its terms and conditions of contracts to deliver
30 health care services before entering into such contracts to ensure that those contracts do not
31 create untenable conflicts of interests do not obviously compromise their ability to fulfill their
32 fiduciary obligations to patients.

33

34 Ongoing evolution in the health care system continues to bring changes to medicine, including
35 changes in reimbursement mechanisms, models for health care delivery, restrictions on referral
36 and use of services, clinical practice guidelines, and limitations on benefits packages. While
37 these changes are intended to enhance quality, efficiency, and safety in health care, they can
38 also put at risk physicians’ ability to uphold professional ethical standards ~~of informed consent~~
39 ~~and fidelity to patients~~ and can impede physicians’ freedom to exercise independent
40 professional judgment and tailor care to meet the needs of individual patients.

41

42 As physicians seek capital to support their practices or enter into various differently structured
43 contracts to deliver health care services—with group practices, hospitals, health plans, or other
44 entities—they should be mindful that while many arrangements have the potential to promote
45 desired improvements in care, some arrangements also have the potential to ~~impede put~~
46 patients’ interests at risk

47

48 When ~~contracting~~ partnering with other entities to provide health care services, physicians
49 should:

- 1 (a) Carefully review the terms of proposed contracts or have a representative do so on
2 their behalf to assure themselves that the arrangement:
3
4 (i) Minimizes conflict of interest with respect to proposed reimbursement
5 mechanisms, financial or performance incentives, restrictions on care or other
6 mechanisms intended to influence physicians' treatment recommendations or
7 direct what care patients receive, in keeping with ethics guidance.
8
9 (ii) Does not compromise physicians' own financial well-being or ability to provide
10 high-quality care through unrealistic expectations regarding utilization of services
11 or terms that expose the physician to excessive financial risk.
12
13 (iii) Allows the physician to appropriately exercise professional judgment.
14
15 (iv) Includes a mechanism to address grievances and supports advocacy on behalf of
16 individual patients.
17
18 (v) Permits disclosure to patients.
19
20 (vi) Enables physicians to participate in, if not outright control, decisions about
21 practice staffing.
22

- 23 (b) Negotiate modification or removal of any terms that unduly compromise physicians'
24 ability to uphold ethical standards.
25

26 When physicians enter into arrangements with partners who may later sell the practice,
27 physicians should seek explicit commitments that subsequent partners will sustain
28 fidelity to patients and respect physicians' professional ethical obligations.
29

30 (Modify HOD policy)

Fiscal Note: Less than \$500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-A-23

Subject: Short-Term Medical Service Trips

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Short-term medical service trips send physicians and physicians in training from wealthier
2 countries to provide care in resource-limited settings abroad for a period of days or weeks. They
3 have been promoted, in part, as a strategy for addressing global health inequities, and have
4 unquestionably benefitted thousands of individual patients. At the same time, short-term medical
5 service trips have a problematic history and run the risk of causing harm to the patients and
6 communities they intend to serve [1]. To minimize harm and ensure significant benefits,
7 volunteers, sponsors, and hosts must jointly prioritize activities to meet mutually agreed-on goals;
8 navigate day-to-day collaboration across differences of culture, language, and history; and fairly
9 allocate host and team resources.

10
11 Ethics guidance can neither redress historical wrongs nor solve the underlying structural issues that
12 drive medical need in resource-limited settings. However, by making explicit the conditions under
13 which short-term medical service trips are ethically sound and articulating the fundamental ethical
14 responsibilities of those who participate in or sponsor such trips, ethics guidance can promote
15 immediate benefit to individuals *and* sustainable benefit for their communities. In addition, ethics
16 guidance can highlight the ways in which power imbalances and neo-colonial assumptions can
17 shape these practices and so may undermine their moral acceptability. This report by the Council
18 on Ethical and Judicial Affairs (CEJA) explores the challenges of short-term medical service trips
19 and offers guidance for physicians, physicians in training, and sponsors to help them address
20 ethical challenges of providing clinical care in resource-limited settings abroad.

21

22 THE APPEAL OF SHORT-TERM MEDICAL SERVICE TRIPS

23

24 Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is
25 difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3
26 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically
27 related [2]. For trainees, in January 2015 the Consortium of Universities for Global Health
28 identified more than 180 websites relating to global health opportunities [3]. The Association of
29 American Medical Colleges found that among students who graduated in 2017–2018 between 25%
30 and 31% reported having had some “global health experience” during medical school [4].

31

32 A variety of reasons motivate physicians and trainees to volunteer for service trips. For many,
33 compelling motivations include the opportunities to help address health inequities, to improve their
34 diagnostic and technical skills as clinicians, or to explore global health as a topic of study [2].

34

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

1 Service trips can also serve the goals of building one’s resume, improving one’s professional
2 prospects, gaining the esteem of peers and family, or simply enjoying international travel [2].

3
4 A NOTE ON TERMINOLOGY

5
6 The literature is replete with different terms for the activity of traveling abroad to provide medical
7 care on a volunteer basis, including “short-term medical volunteerism” [5], “short-term medical
8 missions” [6], “short-term medical service trips” [7,8], “short-term experience in global health”
9 [9,10], “global health field experience” [11], “global health experience,” and “international health
10 experience”[2].

11
12 The Council on Ethical and Judicial Affairs prefers “short-term medical service trips.” This term is
13 clear, concrete, concise, and does not easily lend itself to multiple interpretations or
14 misunderstanding. It also captures the features of these activities that are most salient from the
15 perspective of professional ethics in medicine: their limited duration and their orientation toward
16 service.

17
18 MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

19
20 Traditionally, short-term medical service trips focused on providing clinical care as a charitable
21 activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to
22 address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of improving
23 the health and well-being of host communities [9]. Many also offer training opportunities for
24 medical students and residents [9,10,11]. Ideally, short-term medical service trips are part of larger,
25 long-term efforts to build capacity in the health care systems being visited, and ultimately to reduce
26 global health disparities [9,10].

27
28 The medical needs of host communities differ from those of volunteers’ home countries—
29 volunteers may encounter patients with medical conditions volunteers have not seen before, or who
30 present at more advanced stages of disease, or are complicated by “conditions, such as severe
31 malnutrition, for which medical volunteers may have limited experience” [7]. At the same time,
32 available treatment options will often include medications, procedures or tools with which
33 volunteers are not familiar. As such, global health and limited-resource medicine should be
34 considered a unique area of expertise, requiring specific background and training to practice
35 effectively [12].

36
37 By definition, short-term medical service trips take place in contexts of scarce resources. The
38 communities they serve are “victims of social, economic, or environmental factors” who have
39 limited access to health care [7], and often lack access to food, and economic and political power.
40 They “may feel unable to say no to charity in any form offered” [10]. Moreover, short-term
41 medical service trips take place under the long shadow of colonialism, including medicine’s role
42 [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and
43 dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should
44 recognize that it is a privilege to practice and train in vulnerable communities, and that justice
45 requires reciprocity and equal respect among local and expatriate staff, community members, and
46 patients in this context [9].

47
48 These realities define fundamental ethical responsibilities not only for those who volunteer, but
49 equally for the individuals and organizations that sponsor short-term medical service trips.

1 ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

2
3 Emerging guidelines identify the following ethical duties for participants of short-term medical
4 service trips and organizations sponsoring them: (a) to produce good clinical outcomes, (b) to
5 promote justice and sustainability, (c) to minimize burdens on host communities, and (d) to respect
6 persons and local cultures [2,9,10,11].

7
8 *Promoting Justice & Sustainability*

9
10 If short-term medical service trips are to achieve their goal of improving the health of local host
11 communities, they must commit not simply to addressing immediate, concrete needs, but to helping
12 the community build its own capacity to provide health care. To that end, the near and longer-term
13 goals of trips should be set in collaboration with the host community, not determined in advance
14 solely by the interests or intent of trip sponsors and participants [7,9]. Trips should seek to balance
15 community priorities with the training interests and abilities of participants [10], but in the first
16 instance benefits should be those desired by the host community [9]. Likewise, interventions must
17 be acceptable to the community [9].

18
19 Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask
20 how they can best use a trip's limited time and material resources to promote the long-term goal of
21 developing local capacity. Will the trip train local health care providers? Build local infrastructure?
22 Empower the community [7]? Ideally, a short-term medical service trip will be embedded in a
23 longer-term strategy and collaboratively planned with the host community [7,10].

24
25 *Minimizing Harms & Burdens in Host Communities*

26
27 Just as focusing on the overarching goal of promoting justice and sustainability is foundational to
28 ethically sound short-term medical service trips, so too is identifying and minimizing the burdens
29 such trips place on the intended beneficiaries.

30
31 Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually
32 reimbursed to host communities [9], such trips can place other, less visible burdens on local
33 communities. Physicians, trainees, and others who organize or participate in short-term medical
34 service trips should be alert to possible unintended consequences that can undermine the value of a
35 trip. Trips should not detract from or place significant burdens on local clinicians and resources,
36 particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt
37 relationships between trainees and their home institutions [9,11]. For example, donations of
38 medical supplies can address immediate need, but at the same time create storage and distribution
39 burdens for the local health care system and jeopardize development by the local community of
40 effective solutions to long-term supply problems [7]. Likewise, the expectation that local
41 healthcare and support staff will be available to assist visiting clinicians in addition to (or in place
42 of) their usual duties can disrupt care for their existing patients. It should not be assumed that host
43 communities can absorb additional costs, even on a temporary basis [14]. Particular attention
44 should be paid to the follow-up care that burdens local practitioners and may result in harm to
45 patients in the aftermath of invasive procedures [15].

46
47 Negotiating beforehand how visiting health care professionals will be expected to interact with the
48 host community and the boundaries of the team's mission, skill, and training can reveal possible
49 impacts and allow them to be addressed before the team is in the field. Likewise, selecting team
50 members whose skills and experience map onto the needs and expectations of the host community
51 can help minimize disruptive effects on local practice [11]. Advance preparation should include

1 developing a plan to monitor and address ongoing costs and benefits to patients and host
2 communities and institutions, including local trainees (when the trip includes providing training for
3 the host community), once the team is in the field [11].

4 5 *Respecting Persons & Cultures*

6
7 Physicians and trainees who participate in short-term medical service trips face a host of
8 challenges. Some of them are practical, such as resource limitations, unfamiliar medical needs,
9 living conditions outside their experience, among many others. Others involve successfully
10 navigating language(s) and norms they may never have encountered before, or not encountered
11 with the same immediacy [1,2,9]. Striking a balance between Western medicine's understanding of
12 the professional commitment to respect for persons and the expectations of host communities
13 rooted in other histories, traditions, and social structures calls for a level of discernment,
14 sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a
15 clinician.

16
17 Individuals who travel abroad to provide medical care in resource-limited settings should be aware
18 that the interactions they will have in the field will inevitably be cross-cultural. They should seek to
19 become broadly knowledgeable about the communities in which they will work, such as the
20 primary language(s) in which encounters will occur; predominant local "explanatory models" of
21 health and illness; local expectations for how health care professionals behave toward patients and
22 toward one another; and salient economic, political, and social dynamics. Volunteers should take
23 advantage of resources that can help them cultivate the cultural sensitivity they will need to provide
24 safe, respectful, patient-centered care in the context of the specific host community [7,10,11].
25 Further, trip participants should be mindful that they bring with them their own unexamined
26 cultural beliefs and assumptions about lower income countries, some of which trace back to
27 colonialist, racialized attitudes. For instance, there is a widespread assumption that visiting
28 physicians and trainees possess universally applicable (and unmistakably superior) skills and
29 knowledge by virtue of their association with Western biomedicine [19].

30
31 Individuals do not bear these responsibilities alone. Organizations and institutions that sponsor
32 short-term medical service trips have a responsibility to make appropriate orientation and training
33 available to volunteers before they depart [11], in addition to working with host communities to put
34 in place appropriate services, such as interpreters or local mentors, to support volunteers in the
35 field.

36
37 The ethical obligation to respect the individual patients they serve and their host communities'
38 cultural and social traditions does not obligate physicians and trainees "to violate fundamental
39 personal values, standards of medical care or ethical practice, or the law" [9]. Volunteers will be
40 challenged, rather, to negotiate compromises that preserve in some reasonable measure the values
41 of both parties whenever possible [16]. Volunteers should be allowed to decline to participate in
42 activities that violate deeply held personal beliefs, but they should reflect carefully before reaching
43 such a decision [17].

44 45 GETTING INTO THE FIELD

46
47 To fulfill these fundamental ethical responsibilities, requires meeting other obligations with respect
48 to organizing and carrying out short-term medical service trips. Specifically, sponsoring
49 organizations and institutions have an obligation to ensure thoughtful, diligent preparation to
50 promote a trip's overall goals, including appropriately preparing volunteers for the field

1 experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those
2 programs with which they affiliate themselves [1,2, 9,11].

3 4 *Prepare Diligently*

5
6 Guidelines from the American College of Physicians recognize that “predeparture preparation is
7 itself an ethical obligation” even though this is far from a universal practice [9,cf. 2,12].

8 Collaborative planning can identify what material resources and clinical skills volunteers should be
9 expected to bring to the effort. For example, what activities volunteers should be assigned, or
10 whether local mentors are needed or desirable and how such relationships will be coordinated [11].

11
12 Supervision of trainees also needs to be explicitly arranged and followed up once they reach the
13 field. Studies show that 20% of participants reported inadequate supervision during their trips, and
14 it is common for medical schools to allow “students to arrange experiences abroad without faculty
15 supervision and support” [18, 12]. Allowing students to practice in limited-resource settings
16 without proper supervision is a clear violation of their fiduciary duty.

17
18 Thoughtful preparation includes determining what nonclinical skills and experience volunteers
19 should have to contribute to the overall success of the service opportunity. For example, the goal of
20 supporting capacity building in the local community calls for participants who have “training
21 and/or familiarity with principles of international development, social determinants of health,
22 ...public health systems” and in some cases, health care administration [10,12]. Without this
23 background, interventions may result in “resource wasting and potentially poorer patient care”
24 [12].

25
26 Adequately preparing physicians and trainees for short-term medical service trips encompasses
27 planning with respect to issues of personal safety, vaccinations, unique personal health needs,
28 travel, malpractice insurance, and local credentialing requirements [7]. Equally important, to
29 contribute effectively and minimize “culture shock” and distress, volunteers need a basic
30 understanding of the context in which they will be working [1,2,7]. Without expecting them to
31 become experts in local culture, volunteers should have access to resources that will orient them to
32 the language(s), traditions, norms, and expectations of the host community, not simply to the
33 resource and clinical challenges they are likely to face. Volunteers should have sufficient
34 knowledge to conduct themselves appropriately in the field setting, whether that is in how they
35 dress, how they address or interact with different members of the community, or how they carry
36 out their clinical responsibilities [7]. They also need to know to whom they can turn for guidance.
37 If at all possible, this should be someone from outside the host community, since community
38 members may be reluctant to “push back” against the judgments and actions of volunteers [19].

39
40 Preparation should also include explicit attention to the possibility that volunteers will encounter
41 ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the
42 real possibility that physicians and trainees will encounter situations in which they “are unable to
43 act in ways that are consistent with ethics and their professional values” or “feel complicit in a
44 moral wrong” [9]. In particular, volunteers will be required to assess “how to balance risks and
45 benefits [for very poor and medically vulnerable patients they would not normally encounter] ...
46 how to distribute limited medical resources, and when non-intervention is the appropriate choice”
47 [15]. In addition, volunteers may find that local biases are inconsistent with their own
48 commitments to equity and non-discrimination. Having strategies in place to address dilemmas
49 when they arise and to debrief after the fact can help mitigate the impact of such experiences.
50 Physicians under stress due to difficult ethical situations experience emotional harm and this may,
51 in turn, affect the quality of patient care [12]. In cases of irreducible conflict with local norms,

1 volunteers may withdraw from care of an individual patient or from the mission after careful
2 consideration of the effect withdrawing will have on the patient, the medical team, and the mission
3 overall, in keeping with ethics guidance on the exercise of conscience.

4
5 *Choose Thoughtfully*

6
7 Individual physicians and trainees who volunteer for short-term medical service trips are not in a
8 position to directly influence how such programs are organized or carried out. They can, however,
9 choose to participate in activities carried out by organizations that fulfill the ethical responsibilities
10 discussed above [9,10,11]. Volunteers can select organizations and programs that demonstrate
11 commitment to long-term, community-led efforts to build and sustain local health care resources
12 over programs that provide episodic, stop-gap medical interventions, [10]. Volunteers should strive
13 to avoid working with “volunteer placement organizations” that operate primarily for their own
14 profit and/or lack adequate on-site supervision for trainees [14]. Such organizations exploit the
15 needs of host communities by offering them a small sum per volunteer and then sending volunteers
16 to them without support. Physicians and trainees should also refrain from the “casual or
17 opportunistic” treatment of patients that are not coordinated with local health care systems in
18 advance [20].

19
20 *Measure & Share Meaningful Outcomes*

21
22 Organizations that sponsor short-term medical service trips have a responsibility to monitor and
23 evaluate the effectiveness of their programs, [7,9,10]. The measures used to evaluate program
24 outcomes should be appropriate to the program’s goals as defined proactively in collaboration with
25 the host community [9]. Prospective participants should affiliate themselves with programs that
26 demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather
27 than simple measures of process such as number of procedures performed [7]. Since the success of
28 procedures and programs cannot reasonably be verified if even their medium-term outcomes
29 cannot be monitored, participants should prefer programs that can track patient results over an
30 extended timeframe, even if their own contribution is made in a short time.

31
32 **RECOMMENDATION**

33
34 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the
35 following be adopted and the remainder of this report be filed:

36
37 Short-term medical service trips, which send physicians and physicians in training from wealthier
38 countries to provide care in resource-limited settings for a period of days or weeks, have been
39 promoted as a strategy to provide needed care to individual patients and, increasingly, as a means
40 to address global health inequities. To the extent that such service trips also provide training and
41 educational opportunities, they may offer benefit both to the communities that host them and the
42 medical professionals and trainees who volunteer their time and clinical skills.

43
44 By definition, short-term medical service trips take place in contexts of scarce resources and in the
45 shadow of colonial histories. These realities define fundamental ethical responsibilities for
46 volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals;
47 navigate day-to-day collaboration across differences of culture, language, and history; and fairly
48 allocate host and team resources. Participants and sponsors must focus not only on enabling good
49 health outcomes for individual patients, but on promoting justice and sustainability, minimizing
50 burdens on host communities, and respecting persons and local cultures. Responsibly carrying out

1 short-term medical service trips requires diligent preparation on the part of participants and
2 sponsors in collaboration with host communities.

3
4 Physicians and trainees who are involved with short-term medical service trips should ensure that
5 the trips with which they are associated:

6
7 (a) Focus prominently on promoting justice and sustainability by collaborating with the host
8 community to define mission parameters, including identifying community needs, mission
9 goals, and how the volunteer medical team will integrate with local health care professionals
10 and the local health care system. In collaboration with the host community, short-term medical
11 service trips should prioritize efforts to support the community in building health care capacity.
12 Trips that also serve secondary goals, such as providing educational opportunities for trainees,
13 should prioritize benefits as defined by the host community over benefits to members of the
14 volunteer medical team or the sponsoring organization.

15
16 (b) Seek to proactively identify and minimize burdens the trip places on the host community,
17 including not only direct, material costs of hosting volunteers, but also possible adverse effects
18 the presence of volunteers could have for beneficial local practices and practitioners. Sponsors
19 and participants should ensure that team members practice only within their skill sets and
20 experience.

21
22 (c) Seek to become broadly knowledgeable about the communities in which they will work and
23 take advantage of resources that help them to cultivate the cultural sensitivity they will need to
24 provide safe, respectful, patient-centered care in the context of the specific host community.
25 Members of the volunteer medical team are expected to uphold the ethics standards of their
26 profession and volunteers should insist that strategies are in place to address ethical dilemmas
27 as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from
28 care of an individual patient or from the mission after careful consideration of the effect that
29 will have on the patient, the medical team, and the mission overall, in keeping with ethics
30 guidance on the exercise of conscience. Volunteers should be clear that they may be ethically
31 required to decline requests for treatment that cannot be provided safely and effectively due to
32 resource constraints.

33
34 Sponsors of short-term medical service trips should:

35
36 (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly
37 resources that cannot be assured locally. This includes arranging for local mentors, translation
38 services, and volunteers' personal health needs. It should not be assumed that host
39 communities can absorb additional costs, even on a temporary basis.

40
41 (e) Proactively define appropriate roles and permissible range of practice for members of the
42 volunteer team, so that they can provide safe, high-quality care in the host setting. Team
43 members should practice only within the limits of their training and skills in keeping with
44 professional standards they would deem acceptable for practice in their home country, even if
45 the host country's standards are more flexible or less rigorously enforced.

46
47 (f) Ensure appropriate supervision of trainees, consistent with their training in their home
48 countries, and make certain that they are only permitted to practice independently in ways
49 commensurate with their level of experience in resource-limited settings.

1 (g) Ensure a mechanism for meaningful data collection is in place, consistent with recognized
2 standards for the conduct of health services research and quality improvement activities in the
3 sponsor's country.

4

5 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS*

CEJA Report 04-A-23

Subject: Responsibilities to Promote Equitable Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The disproportionate impact of the COVID-19 pandemic on minoritized and marginalized
2 communities harshly illuminated ongoing inequities in health care across the globe. In the U.S., the
3 pandemic lent new energy to calls for change within and outside medicine and health care. Even as
4 the American Medical Association (AMA) drew on the *Code of Medical Ethics* as a key resource
5 during this public health crisis, the Council on Ethical and Judicial Affairs recognized that
6 additional guidance is needed to explicitly address the ethical implications of social forces that
7 drive how and to whom health care is provided. What role, that is, should physicians and health
8 care institutions play as agents for change in the face of manifest inequity?
9

10 Looking critically at the *Code*, the council observed that existing guidance does indeed speak to
11 matters of fairness or justice in health care. [Principle IX](#) of the *AMA Principles of Medical Ethics*
12 enjoins physicians to “support access to care for all people.” Opinions variously enjoin physicians
13 to promote access to care and address financial barriers to care; to avoid discriminating against or
14 exploiting patients and research participants; to be prudent stewards of health care resources in the
15 interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria;
16 even to ensure that organs and tissues for transplantation are treated as a national rather than a
17 regional or local resource. (Appendix A.)
18

19 At the same time, the council recognized that, for the most part, guidance in the *Code* focuses
20 narrowly on the conduct of individual physicians in their interactions with individual patients. By
21 presenting guidance that addresses the manifestations of inequitable care, not the root causes, the
22 *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of
23 individuals. Yet medicine has long understood that social factors play a critical role in health status
24 and health disparities.
25

26 Such an individualist approach further fails to realize that the social drivers of health have deep and
27 powerful histories. While important and necessary, it is not sufficient to remind physicians of their
28 professional ethical obligations not to discriminate against patients based on explicit and
29 continuously evolving “protected categories” of civil rights law. A professional responsibility to
30 promote equitable care calls for situated, historically informed social and political knowledge of a
31 sort that physicians are not specifically trained in, however, and on forms of discernment and self-
32 reflection on which ethics guidance is generally silent.

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

1 This report by the Council on Ethical and Judicial Affairs seeks to explore more thoughtfully the
2 joint responsibilities that physicians as individual professionals and health care institutions as sites
3 of service have to ensure that all patients in their practices and communities receive “safe,
4 effective, patient centered, timely, efficient, and equitable care.”[\[Opinion 1.1.6\]](#)

5 6 FOUNDATIONAL ETHICS

7
8 At its core, the *Code* rests on an understanding of medicine as inherently a moral activity, rooted in
9 the encounter between “someone who is ill, on the one hand, and someone who professes to heal,
10 on the other,” in the words of physician and ethicist Edmund Pellegrino [1]. The “covenant of
11 trust” established in such encounters binds physicians in a duty of fidelity to patients. The *Code*
12 enjoins physicians, as medical professionals, to “dedicate themselves to providing competent
13 medical care and respect for human dignity and rights.”[\[Principle I\]](#) Doing so encompasses a
14 responsibility for physicians to “examine their own practices to ensure that inappropriate
15 considerations about race, gender identity, sexual orientation, sociodemographic factors, or other
16 nonclinical factors, do not affect their judgment.”[\[Opinion 8.5\]](#) Competent physicians “cultivate
17 continuous self-awareness and self-observation,” and strive to “be attentive to environmental and
18 other factors that may compromise their ability to bring appropriate skills to the care of individual
19 patients and act in the patient’s best interest.”[\[Opinion 8.13\]](#)

20
21 Together these commitments entail physicians’ responsibility to become attentive to how their own
22 perceptions, attitudes, and assumptions can color how they interact with different patients and to
23 take steps to ensure that in delivering care their behavior as individuals neither privileges some
24 patients nor disadvantages others.

25
26 It is also the case that “clinical medicine is the final pathway through which public policies
27 ultimately come to affect the lives of sick persons” [2]. Although Pellegrino had in mind the
28 specific example of managed care as the public policy in question, his observation holds more
29 broadly. Physicians’ duty of fidelity also encompasses the responsibility to recognize and address
30 the ways in which the policies and practices of health care institutions shape patients’ experience of
31 health, illness, and care.

32 33 SHIFTING PERSPECTIVE: FROM “CULTURAL COMPETENCE” TO “STRUCTURAL 34 COMPETENCE”

35
36 Training physicians for “cultural competence” has been promoted as a way to ensure that
37 physicians take account of non-medical dimensions of health and illness, with the ultimate goal of
38 promoting robust respect for patient autonomy and improving quality of care. By learning how to
39 recognize “cross-cultural expressions of illness and health,” the thinking has been, physicians
40 would “be able to counteract the marginalization of patients by race, ethnicity, social class,
41 religion, sexual orientation or other markers of difference” [3]. Yet as the physician anthropologist
42 Arthur Kleinman noted, “culture” is not reducible to a technical skill in which clinicians can
43 develop expertise [4]. Moreover, “cultural factors are not always central to a case, and might
44 actually hinder a more practical understanding of an episode [of illness].”

45
46 Patients’ health status, outcomes, and experiences of care are shaped significantly by social,
47 economic, and political drivers unrelated to cultural understandings of illness and healing [3,5]. To
48 make meaningful progress in achieving equitable care, physicians must recognize how “the
49 pathologies of social systems impact the material realities of their patients’ lives” [3]. As the
50 pathologist Rudolf Virchow noted more than a century ago, “If medicine is to fulfill her great task,

1 then she must enter the political and social life. Do we not always find the diseases of the populace
2 traceable to defects in society” [5]?

3 Truly to address their patients’ health needs, physicians must acquire skills, not of cultural
4 competence, but of “structural competence.” That is:

5
6 the trained ability to discern how a host of issues defined clinically as symptoms, attitudes,
7 or diseases (e.g., depression, hypertension, obesity, smoking, medication “noncompliance,”
8 trauma, psychosis) also represent downstream implications of a number of upstream
9 decisions, about matters such as health care and food delivery systems, zoning laws, urban
10 and rural infrastructures, medicalization, or even about the very definitions of health and
11 illness [3,6].

12 13 ADDRESSING INEQUITY, PROMOTING EQUITABLE CARE¹

14
15 Public health expert Camara Jones observed that when people think about “racism” they think of
16 “personally mediated racism”: the expression of prejudice and discrimination based on “differential
17 assumptions about the abilities, motives, and intentions of others” and “differential actions toward
18 others according to their race” [7]. Personally mediated racism may be intentional or unintentional,
19 manifest in acts of commission and acts of omission. Jones distinguishes this from “institutional
20 racism,” that is, “differential access to goods, services, and opportunities of society by race.”
21 Institutionalized racism, she notes, is structural, “codified in our institutions of custom, practice,
22 and law, so there need not be an identifiable perpetrator.”

23
24 Fulfilling the ethical responsibility to promote equitable care, then, requires that medicine address
25 inequity and discrimination not only at the level of personal interactions among physicians and
26 patients, but equally at the institutional level in the policies and practices that structure interactions
27 within an institution’s walls and in the institution’s interactions with the community (communities)
28 beyond its walls.

29 30 *Personal Interactions*

31
32 Physicians individually cannot be expected to repair structural discrimination and inequity in health
33 care on their own, but they *can* hold themselves accountable for the ways in which their own
34 interactions with patients, families, and fellow health care personnel may contribute to perpetuating
35 discrimination and inequity. Doing so requires that physicians cultivate awareness of how they
36 perceive others, how they speak about or describe persons and medical conditions, and how they
37 approach interactions with patients and others one on one. As first steps, they must address in their
38 own behaviors and implicit biases, such as the use of stigmatizing language and habits of
39 discrediting patients’ knowledge and reports of illness. So too, adopting a trauma-informed care
40 approach can help physicians recognize and address the medical and psychosocial effects for
41 patients of persistent marginalization and discrimination.

42
43 *Implicit bias.* In its 2003 report, *Unequal Treatment*, the Institute of Medicine linked health care
44 professionals’ implicit bias—that is, bias, prejudices, and stereotypes that are not consciously held
45 or recognized—to health disparities [8]. Subsequent research has confirmed that in health care, bias
46 is “negatively associated with both care satisfaction and provider trust among racial/ethnic minority
47 patients” [9]. Among African American patients, for example, physicians’ implicit bias has been

¹ See Appendix B for selected resources for individuals and institutions.

1 shown to be a “relatively consistent predictor of ethnic/racial differences in patients’ subjective
2 experiences with their health care providers” [10].

3
4 Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question
5 [10], but learning to recognize one’s own biases offers a point of entry for cultivating the
6 awareness and critical self-reflection required of physicians as medical professionals. The most
7 effective training will affirm learners’ egalitarian goals and commitment and go beyond raising
8 awareness to teach how to control implicit bias, using active learning techniques that enable
9 learners to practice new skills [10]. Training to “replace negative nonverbal or paraverbal behaviors
10 with positive communication behaviors” can be a practical, attainable way to improve health
11 outcomes [11].

12
13 *Stigmatizing language.* How physicians and other health care personnel speak to and about patients
14 conveys multiple messages, intended and otherwise. Languages that “others” patients, “blames”
15 them for their illness, or casts them as dangerous or threatening can influence care in the moment
16 and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National
17 Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14];
18 Diabetes Australia likewise draws attention to problematic language used about diabetes [15].
19 Phrasing that suggests negative attitudes toward patients, questions patients’ credibility, conveys
20 disapproval of patients, or stereotypes them by race or social class captured in the medical record
21 can undermine care [13]. By the same token, complimenting patients, offering patient-centered
22 accounts of health behaviors that minimizes blame, and incorporating into the record details that
23 personalize the patient as an individual can foster less discriminatory, more effective interactions
24 [13].

25
26 Language that calls into question patients’ credibility or their ability to report their experience of
27 illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients
28 as knowers based on physicians’ expectations, explicit or implicit, about what information is
29 relevant and meaningful for the health care encounter. It privileges a biomedical model of disease
30 over patients’ culturally and socially informed explanatory models and lived experience of illness
31 [4], at times in ways that may actually be harmful to patients when marginalizing their reports of
32 illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care
33 [17]. Epistemic injustice may be both more common and more likely to be harmful for patients
34 whose conditions are poorly understood or contested biomedically—as has been the case with
35 chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient’s
36 contribution to the encounter, physicians undermine trust and the opportunity to create an effective
37 therapeutic relationship.

38
39 *Trauma-informed practice.* Adopting a trauma-informed approach to care offers further
40 opportunity for physicians and other health care professionals to promote equitable care. Trauma-
41 informed care recognizes that trauma “has lasting adverse effects on the individual’s functioning
42 and mental, physical, social, emotional, or spiritual well-being” [18]. “Trauma” encompasses more
43 than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat,
44 for example [19]. It also acknowledges the impact of social, economic, and political structures that
45 cause harm to individuals and communities captured in Paul Farmer’s concept of “structural
46 violence” [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

47
48 Suggestions for implementing trauma-informed care focus on patient-centered communication
49 practices, understanding the effects of trauma, interprofessional collaboration, understanding how
50 one’s own experience of trauma may influence interactions with patients, and specific screening for

1 trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient's
2 past; rather, it offers a way to help improve patients' function and well-being in the present [23].

3 4 *Institutional Policies and Practices*

5
6 Health care institutions share in medicine's fundamental commitment of fidelity to patients.
7 Institutions are the physical and social settings of medical practice, constellations of resources and
8 relationships established to enable the provision of care. Indeed, health care only happens in and
9 through institutions. They reflect the attitudes of clinical professionals, administrators, and society
10 even as they help to form the attitudes of practitioners and shape the delivery of care. In
11 contemporary health care, institutions are the primary medium by which health care interacts with
12 the political, economic, and social structures of society and the major means by which care is
13 delivered. They too bear the ethical responsibilities of medicine.

14
15 The policies and practices of health care institutions importantly determine what care choices are
16 available to patients and physicians. Regardless of size, physician practices, hospitals, and other
17 institutions share responsibility to promote equitable access and care for all. What an institution
18 chooses to know about its patients and staff and how that information factors into institutional
19 decision making and patterns of practice can play a significant role in whether or to what extent the
20 institution promotes equitable care across the board.

21
22 *Social drivers of health.* Just as how physicians perceive, speak about, and interact with others can
23 perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what
24 information the institution captures about the patients it serves, how it does so, how that
25 information is available to clinicians for treatment purposes, and how (or whether) it informs
26 institutional operations. The foundational "explanatory model" of allopathic medicine—to borrow
27 Kleinman's terminology again—grounds diagnosis and treatment jointly in biological function and
28 personal health behaviors, despite ample evidence that social factors powerfully influence health
29 and the delivery of health care [3,20,24].

30
31 Recognition of the significant health impact of structural factors has led to calls to rethink the
32 social history to capture information beyond questions about tobacco or alcohol use to glean
33 information about the socioeconomic and political realities of patients' lives.[25]. For example,
34 initiatives at Brigham & Women's Health and Massachusetts General Hospital have expanded
35 history taking to gather information about patients' particular life circumstances, emotional health,
36 perceptions of health care, and health-related behaviors, as well as access to and utilization of
37 health care [26]. Other institutions have deployed tools to assess patients' "structural
38 vulnerability," including whether someone has money to pay for rent, food, and utilities; a safe,
39 stable place to sleep; friends, family, or others who can provide help when needed; or has
40 experienced discrimination [27,28].

41
42 Some health care institutions have gone beyond collecting data to intervene directly to address the
43 extra-medical factors that so deeply affect health through initiatives to promote income security,
44 medical-legal partnerships to help patients address legal issues that impinge on health status, and
45 clinic-based child literacy programs among others [29,30].

46
47 *Race-based versus race-conscious tools.* As CEJA noted in its 2021 [informational report](#) on
48 augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S.
49 helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when
50 it grounds research and clinical practice in notions of race as unproblematically a genetic,
51 biological characteristic of patients rather than a socially mediated classification of persons [31,32].

1 A growing body of evidence demonstrates that race-adjusted practices, intended to improve care,
2 are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and
3 machine learning tools intended to support prediction of risk or diagnosis [33,34].
4

5 Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the
6 category of race (ethnicity) is, as a proxy measure it does indirectly capture important information
7 about the influence of sociocultural, economic, environmental and genetic factors on health and
8 health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race
9 and ethnicity until better predictors become available [31]. Ensuring that when racial categories are
10 used, they promote equitable health remains of the utmost importance, however.
11

12 *Aversive racism.* How institutions interact with and treat their staff and affiliated personnel can also
13 perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and
14 promoting personnel can reflect aversive racism, “which results from the interplay of . . . social
15 dominance, implicit bias, and in-group favoritism” [35]. Aversive racism is reflected in laments
16 about lack of qualified candidates from historically minoritized communities; it attributes an
17 individual’s inability to thrive within an organization to their personal characteristics or behaviors;
18 and it buys into the “myth of meritocracy” that sees success as a function of ability while ignoring
19 the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender
20 concordance between patient and physician improves patient satisfaction with care and health
21 outcomes, fostering and respecting diversity among health care personnel can be a path toward
22 promoting more equitable care.
23

24 *Equity, safety, and quality improvement.* As a species of “wicked problem,” a term first introduced
25 in the realm of urban planning [36], inequitable care doesn’t lend itself to a simple, one-time
26 solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there
27 is “significant disagreement [among stakeholders] about the nature and cause of the problem and . . .
28 . potential solutions” [37]. By their nature, wicked problems cannot be solved by individual action
29 but must be addressed at the organizational or systems level. To address ongoing inequities in care,
30 institutions must first acknowledge that such inequities exist—they must ensure that they have
31 compendious information about patients and leverage that information to understand where and
32 how change needs to be made. For example, studies show that African American patients with
33 heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn’t
34 apparent without further exploration. A retrospective study at Brigham & Women’s Health found
35 that patients who receive care in a cardiology unit rather than on a medical ward have better
36 outcomes, and that African American and Latinx patients were less frequently admitted to
37 cardiology from the emergency department, as were women, suggesting an institutional pattern that
38 may contribute to disparate outcomes [38].
39

40 Health care institutions in fact already have models on hand that can be adapted to promote
41 equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity
42 initiatives can focus on redesigning the processes and systems that perpetuate discrimination and
43 inequity. In both realms, well-designed initiatives:
44

45 balance [a] systems approach with individual accountability. Both recognize the role of
46 cognitive, often subconscious biases in contributing to unintentional harm. Both highlight
47 the importance of psychological safety to support difficult conversations. And both avoid
48 excessive focus on individual or interpersonal blame. The goal isn’t to shame individual
49 clinicians but to build resilient systems around them that support optimal behaviors [39].

1 ADVOCATING FOR CHANGE

2
3 For both individual health care professionals and for health care institutions, the commitment to
4 serve patients in need entails obligations to examine prevailing attitudes, habits, policies, and
5 practices that determine what care is available to whom and to take steps to remove or re-engineer
6 obstacles that undermine the ability to ensure equitable care for all.

7
8 Physicians have a responsibility to recognize that despite ongoing change in health care and
9 seeming erosion of their authority they *do* have power within their institutions, and to use their
10 voice and status to advocate for change. They have a responsibility to help create opportunities in
11 which to raise challenging issues, to argue for tools to enable difficult conversations, and to
12 develop relationships within their institutions to support one another. Ultimately, physicians have a
13 responsibility to thoughtfully and constructively identify and begin to address the formal and
14 informal expectations that create barriers to equitable care for their patients and equitable treatment
15 of those who provide care and support caregiving within the health care institution.
16 Health care institutions have a responsibility to foster change within their walls, and to
17 acknowledge the multiple roles they play in their communities. Health care institutions are deeply
18 embedded in the life of their communities beyond their role in delivering care—they are
19 employers, purchasers of goods and services, property owners, and civic leadership. A growing
20 number of institutions recognize that as “anchor institutions” within their communities they can—
21 and should—be agents for positive change. As member institutions of the Healthcare Anchor
22 Network observe,

23
24 Hospitals and health systems are critical local economic engines and mission-driven
25 organizations inextricably linked to the long-term well-being of those we serve—because
26 of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more
27 active role in supporting our local economies. We have an opportunity and obligation to
28 improve health and well-being outcomes in the communities we serve and confront
29 economic and social instability in our nation that remain obstacles to that goal [40].

30
31 The Institute for Healthcare Improvement’s Pursuing Equity Initiative identifies five strategies
32 institutions should adopt to eliminate racism—and other forms of discrimination—in health care:

- 33
34 • Understanding the context of racism and other forms of oppression among the
35 communities in which the institution is located;
36 • Normalizing discussion of oppression and listening to stakeholders to understand their
37 experience;
38 • Meaningfully promoting workforce diversity;
39 • Developing and implementing business practices and policies through an equity lens;
40 • Adopting data systems that identify and track equity gaps in clinical outcomes;
41 • Using quality improvement strategies to narrow equity gaps and improve health care
42 for all [41].

43
44 RECOMMENDATION

45
46 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the
47 following be adopted and the remainder of this report be filed:

48
49 Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and
50 a physician who professes to heal. The “covenant of trust” established in that encounter binds
51 physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect

1 the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to
2 recognize and address how the policies and practices of the institutions within which
3 physicians work shape patients' experience of health, illness, and care. As the physical and
4 social settings of medical practice, hospitals and other health care institutions share the duty of
5 fidelity and, with physicians, have a responsibility to ensure that the care patients receive is
6 safe, effective, patient centered, timely, efficient, and equitable.

7
8 Enduring health disparities across patient populations challenge these duties of fidelity.
9 Disparities reflect the habits and practices of individual clinicians and the policies and
10 decisions of individual health care institutions, as well as deeply embedded, historically rooted
11 socioeconomic and political dynamics. Neither individual physicians nor health care
12 institutions can entirely resolve the problems of discrimination and inequity that underlie health
13 disparities, but they can and must accept responsibility to be agents for change.

14
15 In their individual practice, physicians have an ethical responsibility to address barriers to
16 equitable care that arise in their interactions with patients and staff. They should:

- 17
18 a) Cultivate self-awareness and strategies for change, for example, by taking advantage of
19 training and other resources to recognize and address implicit bias;
20 b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-
21 face interactions and entries in the medical record;
22 c) Use the social history to capture information about non-medical factors that affect a
23 patient's health status and access to care to inform their relationships with patients and
24 the care they provide.

25
26 Within their institutions, as professionals with unique knowledge, skill, experience, and status,
27 physicians should collaborate with colleagues to promote change. They should:

- 28
29 d) Support one another in creating opportunities for critical reflection across the
30 institution;
31 e) Identify institutional policies and practices that perpetuate or create barriers to
32 equitable care;
33 f) Participate in designing and supporting well-considered strategies for change to ensure
34 equitable care for all.

35
36 As institutions in and through which health care occurs, hospitals and other health care
37 institutions share medicine's core values and commitment of fidelity, and with it ethical
38 responsibility to promote equitable care for all. Moreover, as entities that occupy positions of
39 power and privilege within their communities, health care institutions are uniquely positioned
40 to be agents for change. They should:

- 41
42 g) Support efforts within the institution to identify and change institutional policies and
43 practices that may perpetuate or create barriers to equitable care;
44 h) Engage stakeholders to understand the histories of the communities they serve and
45 recognize local drivers of inequities in health and health care;
46 i) Identify opportunities and adopt strategies to leverage their status within the
47 community to minimize conditions of living that contribute to adverse health status.

48
49 (New HOD policy)

Fiscal Note: Less than \$500

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Appendix A
Existing Guidance on Justice

	Promote access/ address barriers to care	Do not discriminate	Do not exploit	Distribute benefits fairly	Distribute burdens fairly	Be prudent stewards of shared resources	Advocate for patients	Promote equitable care
Principle VII	X						X	
Principle IX	X							
1.1.2 Prospective patients		X				X		
1.1.6 Quality								X
1.1.7 Physician exercise of conscience		X						
1.1.8 Physician responsibilities for safe patient discharge		X				X	X	
6.2.1 Guidelines for organ transplantation from deceased donors	X	X				X		
6.2.2 Directed donation of organs for transplantation	X			X				
7.1.3 Study design and sampling		X			X			
7.3.2 Research on emergency medical interventions					X			
7.3.3 International research	X		X	X	X			
7.3.10 Expanded access to investigational therapies			x					
8.5 Disparities in health care	X	X		X				
8.11 Health promotion and disease prevention	X							
11.1.1 Defining basic health care	X		X		X		X	
11.1.2 Physician stewardship of health care resources	X						X	
11.1.3 Allocating limited health care resources			X		X	X		
11.1.4 Financial barriers to health care access	X							X
11.2.5 Retainer practices	X							
11.2.6 Mergers of secular and religiously affiliated health care institutions	X							X

APPENDIX B
SELECTED SAMPLE RESOURCES

Racial and Health Equity: Concrete STEPS for Smaller Practices

https://edhub.ama-assn.org/steps-forward/module/2782426?resultClick=1&bypassSolrId=J_2782426

National Institutes of Health – Implicit Bias Training Course

<https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course>

American Academy of Family Physicians – Implicit Bias Resources

<https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html>

⌘

National Institute on Drug Abuse – Words Matter

<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>

Temple Health – Reduce Stigmatizing Language in Healthcare

<https://www.templehealth.org/for-physicians/reduce-stigmatizing-language>

⌘

Indiana University – Trauma-Informed Care Professional Development Certificate

<https://rural.indiana.edu/impact/health/trauma-informed-care-certificate.html>

Texas Department of Family and Protective Services – Trauma-Informed Care Training

https://www.dfps.texas.gov/Training/Trauma_Informed_Care/default.asp

⌘

Centers for Medicare and Medicaid – Accountable Health Communities

Health-Related Social Needs Screening Tool

<https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

American Academy of Family Physicians – Social Needs Screening Tool (Short Form)

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences (PRAPARE)

<https://prapare.org/>

⌘

Racial and Health Equity: Concrete STEPS for Health Systems

https://edhub.ama-assn.org/steps-forward/module/2788862?resultClick=1&bypassSolrId=J_2788862

AMA – Advancing Equity Through Quality and Safety Peer Network

<https://www.ama-assn.org/about/ama-center-health-equity/ama-advancing-equity-through-quality-and-safety-peer-network>

Anchor Mission Playbook – prepared by Rush University

<https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf>

Institute for Healthcare Improvement – Pursuing Equity Learning and Action Network

<https://www.ihl.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx>

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-23

Subject: CEJA’s Sunset Review of 2013 House Policies

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

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

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

2

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

4

5 RECOMMENDATION

6

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

Fiscal Note: Less than \$500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-480.974	Professionalism in Telemedicine and Telehealth	The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate. (BOT Rep. 22, A-13)	Rescind; Directive was fulfilled by issuance of Opinion 1.2.12 – “Ethical Practice in Telemedicine”.
H-185.937	Reproductive Parity	Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care. (Res. 4, I-13)	Retain; remains relevant.
H-245.984	Treatment Decisions for Seriously Ill Newborns	Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03; Reaffirmed: CEJA Rep. 4, A-13)	Retain; remains relevant.
H-25.999	Health Care for Older Patients	The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.. (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-11; Appended: Res. 709, A-13)	Retain; remains relevant.
H-295.865	Discrimination Against Patients	Our AMA opposes the refusal by medical students to participate in the care of patients on	Retain; remains relevant.

	by Medical Students	the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (Res. 1, A-13)	
H-450.942	Patient Adherence to Treatment Plans	It is AMA policy that patient adherence to any medical treatment program is necessary in order to achieve high quality and cost-effective health care. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-478.988	Data Ownership and Access to Clinical Data in Health Information Exchanges	<p>1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues.</p> <p>2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures.</p> <p>3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice.</p> <p>4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13; CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 4, I-13)</p>	Retain; remains relevant.
H-5.989	Freedom of Communication Between Physicians and Patients	It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;	Retain; remains relevant.

		<p>(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;</p> <p>(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and</p> <p>(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients. (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)</p>	
H-520.998	Medical Neutrality	Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. (Res. 505, A-06; Reaffirmed: BOT Rep. 8, I-11; Reaffirmed: Res. 818, I-13)	Retain; remains relevant.
H-525.981	Discrimination of Women Physicians in Hospital Locker Facilities	The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-23)

Introduced by: Medical Student Section

Subject: Opposing Mandated Reporting of LGBTQ+ Status

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Outing is defined as “exposing someone’s lesbian, gay, bisexual, transgender or
2 gender non-binary identity to others without their permission”¹; and
3

4 Whereas, Mandatory reporting can “out” LGBTQ+ individuals and those questioning their
5 sexual orientation and/or gender identity²; and
6

7 Whereas, Protection of LGBTQ+ and questioning individuals from being “outed” prevents
8 additional physical safety risks, stress, mental health degradation, and discrimination^{3,4}; and
9

10 Whereas, There has been a recent wave of directives, resolutions, and laws in states such as
11 Texas and Florida that require mandated reporters, including physicians, to disclose an
12 individual’s gender identity and/or sexual orientation to outside entities^{5,6,7,8}; therefore be it
13

14 RESOLVED, That our American Medical Association amend Policy H-65.959, “Opposing
15 Mandated Reporting of People Who Question Their Gender Identity” by addition to read as
16 follows:
17

18 **Opposing Mandated Reporting of People Who Question Their**
19 **Gender Identity, H-65.959**

20 Our AMA opposes mandated reporting of individuals who identify
21 as part of the LGBTQ+ community and those who question or
22 express interest in exploring their gender identity and/or sexual
23 orientation. (Modify Current Policy)
24

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

Received: 3/31/23

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RELEVANT AMA POLICY

Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959

Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.

Citation: Res. 015, A-19;

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19;

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-23)

Introduced by: Medical Student Section

Subject: Exclusion of Race and Ethnicity in the First Sentence of Case Reports

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Patients of color often have worse healthcare outcomes than White patients,
2 particularly noticeable in the decreased life expectancies for Black and Indigenous patients^{1,2};
3 and
4

5 Whereas, Non-Hispanic White patients report lower satisfaction with their doctors, and patients
6 of color routinely report worse treatment and experiencing bias and racism when accessing
7 care^{1,3}; and
8

9 Whereas, Medical racism has been present throughout history and its legacy continues to
10 unfold today, manifesting as unethical experiments and substandard, unnecessary, or incorrect
11 treatments being given to minoritized racial groups historically and continuing to be discovered
12 even today^{4,5}; and
13

14 Whereas, The perpetuation of racial bias begins early in preclinical medical education, such as
15 when race is taught to be a biological factor or a substitute for education, income, or genetics,
16 which also deeply harms medical trainees from minoritized communities by perpetuating the
17 belief that their race makes them biologically different, unusual, or inferior^{6,7}; and
18

19 Whereas, A common example is that Black race is often used as a proxy for sickle cell trait or
20 disease, ignoring that sickle cell genetics can and do occur in people of any race, leading to
21 missed diagnoses in some individuals and also opening the possibility of “premature closure” in
22 diagnoses of Black patients experiencing symptoms that are similar to sickle cell but are
23 occurring due to a different pathological process^{7,8}; and
24

25 Whereas, Analyses of lecture slides and clinical vignettes used in medical education have found
26 that race or ethnicity is often presented as a biological risk factor or linked to certain behaviors,
27 without addressing social context or history⁹⁻¹¹; and
28

29 Whereas, During training, medical students learn to use race as a heuristic in preclinical exams
30 and on standardized licensing examinations, with a study of first- and second-year medical
31 students finding that all participants believed that if race was used in a board-style question, it
32 was likely relevant to answering the question correctly¹²⁻¹⁴; and
33

34 Whereas, A 2017 study of common USMLE Step 1 preparation material found that of 2,011
35 questions, 455 (20.6%) referred to race or ethnicity in the question stem, answer, or educational
36 objective, with 412 cases (90.5%) only mentioning it as a descriptor without a stated educational
37 objective, while the other 43 cases (9.45%) made race or ethnicity central to the case¹⁵; and
38

39 Whereas, It has been argued, including in the *AMA Journal of Ethics*, that race should (a) be
40 obtained as directly identified by the patient themselves and (b) be recorded in the social

1 history, rather than the first line in a case presentation, to help decrease the possibility of race
2 being inappropriately used as a proxy while still recording this social factor as identified by the
3 patient so that important social impacts like the patient's experiences with discrimination and
4 racism can still be understood^{10,16-18}; and
5

6 Whereas, The American Medical Association has committed to recognizing and addressing the
7 harmful effects of racism in medicine, medical training, and medical research (H-65.952, H-
8 65.953, D-350.984, H-165.822, D-350.981); therefore be it
9

10 RESOLVED, That our American Medical Association encourage curriculum and clinical practice
11 that omits race and/or ethnicity from the first sentence of case reports and other medical
12 documentation (New HOD Policy); and be it further
13

14 RESOLVED, That our AMA encourage the maintenance of race and ethnicity in other relevant
15 sections of case reports and other medical documentation. (New HOD Policy)
16

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

Received: 3/27/23

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RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20;

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Citation: BOT Action in response to referred for decision Res. 602, I-15;

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health

needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21; Reaffirmed: CMS Rep. 5, A-22;

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-23)

Introduced by: Medical Student Section

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship
Need Blind Model for Organ Procurement and Transplantation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Department of Homeland Security (DHS) estimates there were 11.4 million
2 undocumented immigrants in the United States as of 2018, 5,500 - 8,857 of whom are living
3 with end-stage renal disease (ESRD)¹⁻³; and
4

5 Whereas, Patients with ESRD who are citizens or, in some cases, documented non-citizens are
6 eligible for coverage through Medicare, but undocumented non-citizens are not eligible for these
7 benefits^{4,5}; and
8

9 Whereas, The cost of hemodialysis is exceptionally high, with a recent analysis suggesting a
10 cost of between \$40,000 - \$120,000 per year depending on the type of coverage⁶; and
11

12 Whereas, Undocumented immigrants who cannot afford the cost of maintenance hemodialysis
13 must rely on emergent-only hemodialysis after they develop life-threatening metabolic
14 disturbances, as the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates
15 that all states must provide federally funded emergency medical treatment irrespective of a
16 patient's ability to pay⁷; and
17

18 Whereas, California, New York, Illinois, Washington, and Colorado have passed laws that
19 recognize ESRD as an emergency medical condition, which allows Medicaid to be extended to
20 patients with ESRD for dialysis in outpatient clinics, but the remaining 45 US states do not have
21 similar exemptions⁸⁻¹²; and
22

23 Whereas, A cost-effective alternative approach to maintenance hemodialysis is kidney
24 transplantation¹³⁻¹⁵; and
25

26 Whereas, Current ethical and legal guidelines dictate that medical need alone should determine
27 how organs are allocated for transplant, including the AMA Code of Ethics 11.1.3, "Allocating
28 Limited Health Care Resources"; and
29

30 Whereas, Only 1% of all kidney transplant recipients per year are non-citizens, which is grossly
31 out of proportion to the 2-3% annual contribution to the donor organ pool made by this same
32 population, suggesting that citizenship status is adversely impacting the ability of noncitizens to
33 receive needed organs¹⁶; and
34

35 Whereas, While organs may be allocated to undocumented immigrants, current policy excludes
36 this patient population from receiving federal funding (and often state and local funding as a
37 result) to cover their transplantation and post-transplantation care^{5,17-19}; and

1 Whereas, Undocumented persons are not only often unable to afford potentially curative kidney
2 transplants, they are also often unable to pay for costly post-transplant immunosuppressive
3 medications, which may lead to graft failure over time²⁰; and
4

5 Whereas, Undocumented persons experience barriers to transplant eligibility for organs other
6 than the kidneys, with a recent study of liver transplants indicating that undocumented persons
7 rarely have access to liver transplantation and experience long wait times that can negatively
8 affect outcomes in the transplant recipients²⁰⁻²³; and
9

10 Whereas, Each transplant center sets their own rules for organ waiting list eligibility, which may
11 include financial status and insurance coverage alongside patient health and the presence of
12 risk factors, thus reducing the likelihood of accessing an organ transplant for undocumented
13 immigrants and legally present noncitizens who are uninsured²⁴; and
14

15 Whereas, The United Network for Organ Sharing (UNOS) is a private non-profit that contracts
16 with the federal government to oversee the Organ Procurement Transplant Network (OPTN),
17 which manages and maintains a national registry for organ matching in the US²⁵⁻²⁷; and
18

19 Whereas, Data from the United Network for Organ Sharing (UNOS) shows that from 2013-2018,
20 heart and lung transplant outcomes were equivalent to or even better among non-citizens
21 compared to citizens at one year, showing that citizenship status does not adversely impact
22 transplant outcomes²⁸; and
23

24 Whereas, The OPTN collects voluntary data on citizenship status for both organ donors and
25 recipients for two main purposes: first, to study the contribution of non-US citizens/non-US
26 residents to the organ transplantation network in the US, and second, to monitor transplant
27 centers to prevent medical transplant tourism, which is a widely condemned and often
28 exploitative practice wherein wealthy patients travel abroad to purchase or obtain organs from
29 poorer donors that can impinge on a host country's ability to provide for the transplant needs of
30 its own population^{29,30}; and
31

32 Whereas, Current OPTN policy states that a candidate's citizenship or residency status should
33 not be considered when making decisions about organ allocation³¹; therefore be it
34

35 RESOLVED, That our American Medical Association support initiatives that decrease financial
36 and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients,
37 regardless of immigration status, excluding medical tourism as defined in the AMA Code of
38 Ethics 1.2.13 (New HOD Policy); and be it further
39

40 RESOLVED, That our AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for
41 Organ Transplantation from Deceased Donors to consider the concerns of differential access
42 based upon immigration status (Directive to Take Action); and be it further
43

44 RESOLVED, That our AMA amend H-370.982 by addition to read as follows:
45

46 **Ethical Considerations in the Allocation of Organ and Other**
47 **Scarce Medical Resources Among Patients, H-370.982**

48 Our AMA has adopted the following guidelines as policy:

- 49 (1) Decisions regarding the allocation of scarce medical resources among
50 patients should consider only ethically appropriate criteria relating to medical
51 need. (a) These criteria include likelihood of benefit, urgency of need,
52 change in quality of life, duration of benefit, and, in some cases, the amount

1 of resources required for successful treatment. In general, only very
2 substantial differences among patients are ethically relevant; the greater the
3 disparities, the more justified the use of these criteria becomes. In making
4 quality of life judgments, patients should first be prioritized so that death or
5 extremely poor outcomes are avoided; then, patients should be prioritized
6 according to change in quality of life, but only when there are very
7 substantial differences among patients. (b) Research should be pursued to
8 increase knowledge of outcomes and thereby improve the accuracy of these
9 criteria. (c) Non-medical criteria, such as ability to pay, social worth,
10 immigration status, perceived obstacles to treatment or follow-up, patient
11 contribution to illness, or past use of resources should not be considered.
12 (2) Allocation decisions should respect the individuality of patients and the
13 particulars of individual cases as much as possible. (a) All candidates for
14 treatment must be fully considered according to ethically appropriate criteria
15 relating to medical need, as defined in Guideline 1. (b) When very
16 substantial differences do not exist among potential recipients of treatment
17 on the basis of these criteria, a "first-come-first-served" approach or some
18 other equal opportunity mechanism should be employed to make final
19 allocation decisions. (c) Though there are several ethically acceptable
20 strategies for implementing these criteria, no single strategy is ethically
21 mandated. Acceptable approaches include a three-tiered system, a minimal
22 threshold approach, and a weighted formula.
23 (3) Decision making mechanisms should be objective, flexible, and
24 consistent to ensure that all patients are treated equally. The nature of the
25 physician-patient relationship entails that physicians of patients competing
26 for a scarce resource must remain advocates for their patients, and
27 therefore should not make the actual allocation decisions.
28 (4) Patients must be informed by their physicians of allocation criteria and
29 procedures, as well as their chances of receiving access to scarce
30 resources. This information should be in addition to all the customary
31 information regarding the risks, benefits, and alternatives to any medical
32 procedure. Patients denied access to resources have the right to be
33 informed of the reasoning behind the decision.
34 (5) The allocation procedures of institutions controlling scarce resources
35 should be disclosed to the public as well as subject to regular peer review
36 from the medical profession.
37 (6) Physicians should continue to look for innovative ways to increase the
38 availability of and access to scarce medical resources so that, as much as
39 possible, beneficial treatments can be provided to all who need them.
40 (7) Physicians should accept their responsibility to promote awareness of
41 the importance of an increase in the organ donor pool using all available
42 means. (Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

Citation: CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12; Reaffirmed: CEJA Rep. 4, A-22;

E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician's primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.

Physicians who participate in transplantation of organs from deceased donors should:

- (a) Avoid actual or perceived conflicts of interest by ensuring that:
 - (i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;
 - (ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.
- (b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
- (c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.

(d) Ensure that the prospective recipient (or the recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.

(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.

(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.

(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

Issued: 2016

E-1.2.13 Medical Tourism

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large.

Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient's decision to seek health care abroad. (IV, V, VI)

Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.

(b) Advocate for education for health care professionals about medical tourism.

(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.

(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual's concerns and wishes about care.

(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.

(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.

(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.

(i) Offer their best professional guidance about a patient's decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to

obtain specific care abroad not to be in the patient's best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.

(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician's prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:

- (i) the nature and duration of the patient-physician relationship;
- (ii) the likely impact on the individual patient's well-being;
- (iii) the burden declining to provide follow-up care may impose on fellow professionals;
- (iv) the likely impact on the health and resources of the community.

Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

Issued: 2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, Considering sex, which is assigned at birth, and gender, which is how an individual
2 identifies, are necessary to provide personalized care to patients^{1,2}; and
3
- 4 Whereas, The importance of understanding sex and gender differences in clinical medicine was
5 recognized and agreed upon by the 103rd Congress of the United States via the passage of the
6 National Institutes of Health (NIH) Revitalization Act of 1993, which mandated that NIH-funded
7 clinical trials include women and minoritized populations as participants, and evaluate outcomes
8 by sex and race or ethnicity^{3,4}; and
9
- 10 Whereas, Recent studies have revealed that the NIH Revitalization Act of 1993 has not resulted
11 in significant increases in reporting results by sex, race, or ethnicity⁴⁻⁶; and
12
- 13 Whereas, Published randomized controlled trials frequently lack adequate enrollment of women
14 and sexual and gender minority participants, and fail to stratify of outcomes by sex or gender⁶⁻⁸;
15 and
16
- 17 Whereas, In a study of 215 leading surgery journals, only 6.7% of editors were women⁹; and
18
- 19 Whereas, The lack of diversity in sex and gender among authors, editors, peer reviewers, and
20 others involved in the review process for articles increases the threat of implicit bias affecting
21 the editorial review process⁹; and
22
- 23 Whereas, A study evaluating whether the sex of research participants influenced the
24 recommendation to publish an article revealed that "reviewers were almost twice as likely to
25 recommend publication for research conducted in men than the same research conducted in
26 women"¹⁰; and
27
- 28 Whereas, Following the conduction of an internal audits of their peer-review process to self-
29 monitor whether a gender bias or other biases impeding inclusivity existed amongst their
30 journals, the American Geophysical Union encouraged other publishers and societies to
31 conduct similar audits to establish a baseline for measuring progress and to promote
32 accountability¹¹; and
33
- 34 Whereas, Public access to medical research can promote collaboration between researchers
35 and help patients make informed decisions about their health^{12,13}; and
36
- 37 Whereas, There is a lack of harmonized, sex-disaggregated and gender-disaggregated
38 statistics available to both the research community and the general public^{6,10}; and

1 Whereas, Even when sex-disaggregated and gender-disaggregated data or clinical practice
2 guidelines are published, patients, physicians, community-based researchers, and research-
3 scientists will often remain unaware of their existence, as the resources fail to use sex-specific
4 and gender-specific terminology necessary to be cached by search engines⁷; and
5

6 Whereas, The United States federal government has demonstrated its capacity to support
7 efforts to provide centralized access to sex-stratified and gender-stratified data for patients,
8 physicians, and researchers via the establishment of digital repositories and publicly
9 downloadable databases by the National Institute of Diabetes and Digestive and Kidney
10 Diseases (NIDDK), National Center for Biotechnology Information, National Hospital Ambulatory
11 Medical Care Survey, and National Hospital Ambulatory Medical Care Survey^{15,16}; and
12

13 Whereas, In a Listening Session with transgender adults organized by the Food and Drug
14 Administration (FDA), respondents unanimously expressed enthusiasm towards “being part of
15 registry to collect information about surgical and medical treatment”^{16,17}; and
16

17 Whereas, These federal projects have developed and maintained confidentiality standards and
18 protocols that have protected patient privacy to date^{16,18}; and
19

20 Whereas, Despite the passage of the NIH Revitalization Act of 1993, only 3 of the 22 medical
21 devices that the Food and Drug Administration (FDA) deemed “highest risk” or “novel” from
22 2014 to 2017 provided subgroup analysis for both effectiveness and safety or both sensitivity
23 and selectivity for gender, race, and age¹⁹; and
24

25 Whereas, Clinical guidance criteria for implantable cardioverter defibrillators use, a device
26 subject to FDA approval, is based on clinical trials comprised of less than 30% females, and in
27 which evidence of safety and effectiveness is much stronger in males²⁰; and
28

29 Whereas, FDA studies that do not account for sex and gender may be ineffective or even
30 harmful to women, and sexual and gender minorities’ patients, as illustrated by an FDA study of
31 the LUTONIX drug-coated balloon catheter device, in which there was an increased
32 effectiveness in the total population primarily attributed to male patients, while female patients
33 had significantly worse outcomes with 51% effectiveness in bladder control compared to 70% in
34 the control group¹⁹; and
35

36 Whereas, Women experience twice as many adverse drug reactions as men due to possible
37 overmedication, with one study showing 88% of evaluated FDA-approved drugs had altered
38 drug pharmacokinetic profiles leading to higher blood concentrations and elevated elimination
39 times in women than in men, and 96% of evaluated drugs with higher pharmacokinetic values in
40 women than men had a higher incidence of adverse drug reactions in women²¹; and
41

42 Whereas, Current medication labeling practices maintain a binary conception of gender, which
43 has impeded sexual and gender minority patients from obtaining necessary medication¹⁷;
44 therefore be it
45

46 RESOLVED, That our American Medical Association facilitate the inclusion of women and
47 sexual and gender minority participants in clinical research studies and reporting of how the sex
48 and gender of these participants influenced study outcomes requires the cooperation of
49 researchers, federal agencies, and journal editors, by amending Policy H-525.988, “Sex and
50 Gender Differences in Medical Research,” by addition and deletion to read as follows:

Sex and Gender Differences in Medical Research, H-525.988

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; ~~and~~
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative-;
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities;
and
(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

An Expanded Definition of Women's Health H-525.976

Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

Citation: CSAPH Rep. 05, A-16;

Comparative Effectiveness Research H-460.909

The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

Citation: CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09; Reaffirmation I-10; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 4, I-19;

Mitigating Gender Bias in Medical Research H-460.891

Our AMA will advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process.

Citation: Res. 610, A-19;

Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research H-460.911

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial

accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Citation: Res. 005, A-18;

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19;

E-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.

Issued: 2016

Alzheimer's Disease H-25.991

Our AMA:

- (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;
- (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
- (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
- (4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
- (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
- (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and
- (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-23)

Introduced by: Medical Student Section

Subject: Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, There is a lack of inclusivity in the hospital and operating rooms when it comes to the
2 availability of modest professional uniforms and hospital gowns^{1,2}; and
3
- 4 Whereas, Wearing modest or hijab-compliant professional attire is religiously obligatory for
5 Muslim women observing hijab and a critical part of Muslim identity³; and
6
- 7 Whereas, Members of the medical care team or other patients who do not identify as Muslims
8 may also want to wear more modest clothing, due to spiritual, personal, or even medical
9 reasons; and
10
- 11 Whereas, Certain practicing Mormons, Amish, Orthodox Jews, and Christians use modest
12 apparel⁴; and
13
- 14 Whereas, A 2020 study found that 4.5% of the total US physician workforce consists of
15 physicians who are international medical graduates of Muslim-majority nations, and this number
16 does not include Muslim physicians born in the United States so the total number of US Muslim
17 physicians is likely higher⁵; and
18
- 19 Whereas, The Institute for Social Policy and Understanding's (ISPU) *American Muslim Poll*
20 *2022: A Politics and Pandemic Status Report* found that Muslims were the most likely religious
21 group to experience discrimination in institutional settings, especially when seeking healthcare
22 services⁶; and
23
- 24 Whereas, A national survey of American Muslim physicians in 2013 found that 24% of Muslims
25 surveyed experience religious discrimination on the job⁷; and
26
- 27 Whereas, There are many accounts of hijab-wearing Muslim women who state that their
28 medical duties are hindered due to a lack of modest attire, such as wearing an N-95 respirator
29 over a hijab⁸; and
30
- 31 Whereas, Modest or 'halal' scrub options and medical hijabs exist, but are not laundered by
32 hospitals or supplied by hospital-approved third parties, and therefore are not allowed into the
33 operating room per hospital policy⁸⁻¹⁰; and
34
- 35 Whereas, A 2018 study found wearing long sleeves while prepping a patient in the operating
36 room decreases airborne contaminants¹¹; and

1 Whereas, The Association of Perioperative Registered Nurses (AORN) released guidelines in
2 2015 that require individuals who are scrubbed to wear long-sleeves in the operating room¹²;
3 and
4

5 Whereas, Despite concerns that long-sleeves can cause increased surgical site infections, a
6 study found that the implementation of AORN's guidelines about wearing long-sleeves in the
7 operating room did not affect the frequency of surgical site infections¹³; and
8

9 Whereas, A 2021 systematic review of 59 articles from 2000-2019 found no correlation between
10 what was worn in the operating room and the incidence of surgical site infections¹⁴; and
11

12 Whereas, A 2021 systematic review found that research studying the association between
13 clothing in the operating room and surgical site infections is lacking, despite guidelines like
14 those of AORN's that stipulate operating room attire requirements¹⁴; and
15

16 Whereas, The U.S. Equal Employment Opportunity Commission states, "...employers are
17 required by federal law to make exceptions to their usual rules or references to permit
18 employees to observe religious dress and grooming practices," and that hospitals with restrictive
19 policies could be liable for denial of accommodation without evidence that religious garb and
20 grooming pose a workplace risk or hazard¹⁵; and
21

22 Whereas, Modest, hospital-provided scrubs can serve as professional, clean and functional
23 attire⁸; and
24

25 Whereas, According to OSHA, personal protective equipment (PPE) is any equipment that is
26 worn by an individual whose purpose is to protect against exposures to hazardous materials
27 that can cause bodily harm in the workplace¹⁶; and
28

29 Whereas, According to OSHA, PPE should "fit comfortably, encouraging worker use" but hijab
30 observers often need to sacrifice comfort and ease of access for modesty^{9,16}; and
31

32 Whereas, According to OSHA, scrubs are considered "street clothing", not PPE, and therefore
33 should be covered under gowns, aprons, and laboratory coats in the operating room¹⁷; and
34

35 Whereas, Before entering the operating room at most institutions, scrubs must be covered by an
36 additional sterile gown after a healthcare provider properly scrubs in, covering anything they
37 may be wearing below, including hospital laundered scrubs¹⁸; and
38

39 Whereas, The American Hospital Association promotes the enhancement of cultural
40 competency because cultural competency is recognized as an essential means of reducing
41 racial and ethnic disparities in health care¹⁹; and
42

43 Whereas, Cultural competence is defined as the ability of providers and organizations to
44 effectively deliver health care services that meet the social, cultural, and linguistic needs of
45 patients^{20,21}; and
46

47 Whereas, Cultural competence in the healthcare setting includes incorporating culture-specific
48 attitudes and values into health promotion tools and willingness to make clinical settings more
49 accessible to patients^{20,21}; and

- 1 Whereas, Lack of cultural competence may lead to patient dissatisfaction^{20,21}; and
2
3 Whereas, Hospitals should provide modest scrubs for employees and hospital attire options for
4 patients as well to promote cultural and religious inclusivity^{2,6}; and
5
6 Whereas, Some patients require modesty in interactions and in clothing during clinical
7 encounters and procedures^{2,22}; and
8
9 Whereas, Failure to provide modest accommodations for patients who require it is a predictor of
10 delayed healthcare in certain patient populations²³; and
11
12 Whereas, One approach of the AMA's 2021-2023 Organizational Strategic Plan to Embed
13 Racial Justice and Advance Health Equity is to build alliances and share power with physicians
14 and stakeholders who have been historically marginalized & minoritized to "develop structures
15 and processes to consistently center [their] experiences and ideas"²⁴; and
16
17 Whereas, Policy H-440.856 states that the AMA encourages all physicians to wear clean,
18 appropriate attire, and research into textile transmission of infections²⁵; and
19
20 Whereas, Policy H-440.810 states that the AMA encourages diverse PPE designs to fit all
21 healthcare professional's body types, cultural expressions, and practices, but this policy fails to
22 consider the religious obligations of modesty that some may follow and the fact that scrubs are
23 not considered PPE according to OSHA²⁶; and
24
25 Whereas, Policy H-65.949 states that the AMA encourages healthcare institutions to provide
26 PPE that takes both patient safety and healthcare worker's natural hair/hairstyles or cultural
27 headwear into account, but does not explicitly state whether this applies to religious and cultural
28 modest clothing²⁷; therefore be it
29
30 RESOLVED, That our American Medical Association support the provision of safe, culturally
31 and religiously sensitive operating room scrubs and hospital attire options for both patients and
32 employees. (New HOD Policy)

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

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RELEVANT AMA POLICY

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.

6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

Citation: Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21;

Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949

Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.

Citation: Res. 006, A-22;

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856

Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.

Citation: BOT Rep. 3, A-10; Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-23)

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: Ensuring Privacy as Large Retail Settings Enter Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

-
- 1 Whereas, Large retail settings such as Amazon, CVS, Dollar General, Target, and Wal-Mart are
2 in the process of moving into the provision of general and mental healthcare; and
3
4 Whereas, Concerns have been raised by medical providers about the business models, role of
5 medical professionals, and quality of medical services provided by these organizations; and
6
7 Whereas, Amazon has not been transparent regarding if or how its medical databases would be
8 integrated with its other massive customer databases; and
9
10 Whereas, Amazon has not been transparent regarding how it will ensure the privacy of medical
11 data it accumulates through its healthcare businesses; therefore be it
12
13 RESOLVED, That our American Medical Association study privacy protections and the potential
14 for data breaches of healthcare records in large retail settings. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action

should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider.

Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire;
Rhode Island; Vermont

Subject: Independent Medical Evaluation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Independent Medical Evaluation (IME) is typically a non-voluntary, non-
2 consensual legally obligated mandate for persons who are injured or disabled to be evaluated
3 by insurers or employers^{1, 11}; and
4

5 Whereas, The IME evaluation does not involve the typical safeguards of a fiduciary and privacy
6 obligations of the physician to the patient and under current CEJA opinion provides a "limited
7 patient-physician relationship"^{2, 3}; and
8

9 Whereas, The potential for undue influence of personal and corporate interests exist for IMEs.
10 The compensation of the IME examiner inherently raises concerns about potential conflicts of
11 interest and a pro-employer/carrier bias is embedded in the methodology IMEs, and that the
12 practical impact of the IME approach is to reduce the recognition of occupationally related
13 health conditions and to minimize the reported disability associated with such conditions^{4, 5, 6, 12};
14 and
15

16 Whereas, The selection of the IME examiner often involves limited input from the patient; and
17

18 Whereas, There are no consistent national standards safeguarding patient's privacy, or ability of
19 the patient to record, document or bring their own physician or advocate to the IME
20 examination; and
21

22 Whereas, There is a paucity of research documenting a patient centric, objective unbiased
23 outcomes which protect the injured or disabled patient being mandated to undergo an IME^{14, 15};
24 and
25

26 Whereas, There is no established/longitudinal relationship between the IME examiner and the
27 injured or disabled patient; and
28

29 Whereas, There are many different standards to which the examiner must adhere when
30 completing an IME which include but are not limited to federal regulations set forth by the Social
31 Security Administration, local state laws, and the American Medical Association's Guidelines to
32 the Evaluation of Permanent Impairment. There are also guidelines set forth by many American
33 colleges and boards of medical specialties including the American College of Surgeons,
34 American Society of Interventional Pain Physicians, and the American College of Occupational
35 and Environmental Medicine. In addition to many nationally created guidelines, the examiner
36 may also consult the World Health Organizations Disability Assessment Schedules I and II,
37 which provide a simple and unified approach to the disabled patient. No uniform qualifications

1 training or certification have been established for physicians performing IME. Best practices
2 have been suggested by some experts in the field of IME^{6, 16}; and
3 Whereas, There have been a long history of journalistic investigations including the *New York*
4 *Times* documenting the inherent problems of the IME process^{8, 9}; and

5
6 Whereas, Worker and disabled patient advocacy groups have highlighted that injured and
7 disabled patients are discouraged from filing claims for fear of retaliation. The extent of fraud in
8 workers compensation is 1 – 2 %^{10, 17}; and

9
10 Whereas, A substantial body of literature exists questioning the ethical foundation of
11 independent medical examinations (IMEs) in medicolegal cases. IME physicians are prone to
12 biases, in that they are financially motivated to maintain a positive relationship with the
13 insurance carriers that hire them^{12, 13}; and

14
15 Whereas, The following areas should be important considerations: a) qualifications for those
16 performing IME; b) appropriate privacy and informed consent for IME; c) fair and reasonable
17 policies and procedures including due process for including recording, advocacy and access to
18 the examination to their treating physicians for an IME; and d) model state or federal legislation,
19 rules, or regulations to protect the interest of those injured and disabled; therefore be it

20
21 RESOLVED, That our American Medical Association study and report back at the 2024 Annual
22 Meeting on the Independent Medical Evaluation (IME) process and recommend standards and
23 safeguards to protect injured and disabled patients. (Directive to Take Action)

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

Received: 5/2/23

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Reference Committee A

CMS Report(s)

- 02 Medicare Coverage of Dental, Vision, and Hearing Services
- 03 Private Insurer Payment Integrity
- 04 Bundled Payments and Medically Necessary Care
- 07 Reporting Multiple Services Performed During a Single Patient Encounter

Resolution(s)

- 101 Updating Physician Job Description for Disability Insurance
- 102 Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use
- 103 Movement Away from Employer-Sponsored Health Insurance
- 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
- 105 Studying Population-Based Payment Policy Disparities
- 106 Billing for Traditional Healing Services
- 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
- 108 Sustainable Reimbursement for Community Practices
- 109 Improved Access to Care For Patients in Custody of Protective Services
- 110 Long-Term Care Coverage for Dementia Patients

REPORT 02 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to “support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Expansion of Medicare coverage to new services has been debated extensively by Congress. Proponents of expanding Medicare coverage for dental, vision, and hearing services have frequently suggested that Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B; beneficiaries could enroll in Medicare Advantage (Part C) plans; a new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created; or some form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established.

Nonetheless, while many believe that Medicare beneficiaries should have coverage for a wider range of services, significant obstacles remain. Given the current rate of inflation, the \$358 billion projection from Congressional Budget Office in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. Further, given that Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum, and we must be sensitive to what implications adding these services could mean for payment and access to other current health care services for Medicare beneficiaries.

While the Council acknowledges the potential value of expanded Medicare benefits, it believes that the current options in place for beneficiaries to access these services are adequate. In terms of the current political environment, at the time that this report was written, Congress had failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. Broader Medicare physician payment reform remains one of the highest priorities of the AMA, under the AMA’s Recovery Plan for America’s Physicians.

The Council reemphasizes the importance of working with the American Dental Association regarding strategies to expand dental coverage to Medicare beneficiaries. The Council believes that the AMA can be most influential in addressing the need for hearing services by improving mechanisms already in place. Additionally, the AMA can encourage the United States Preventive Task Services Task Force to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Finally, the Council believes that AMA policy on vision coverage can be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 02-A-23

Subject: Medicare Coverage of Dental, Vision, and Hearing Services
(Referred Resolve Clause of Alternate Resolution 113-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

1 At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113,
2 which asked the American Medical Association (AMA) to “support new funding that is
3 independent of the physician fee schedule for Medicare coverage of 1) preventive dental care,
4 including dental cleanings and x-rays, and restorative services, including fillings, extractions, and
5 dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services
6 and hearing aids.

7
8 Resolution 119 was combined with similar resolutions 113 and 114 to become Alternate Resolution
9 113, which was passed in part to become Policy D-185.972, “Increasing Patient Access to Hearing,
10 Dental, and Vision Services.” The policy states that the AMA will promote awareness of hearing
11 impairment as a potential contributor to cognitive impairment later in life and encourage further
12 research on this topic. This policy also encourages increased patient access to both vision and
13 dental services.

14
15 There was mixed testimony heard on these related items. There were several calls for referral, but
16 support for ensuring that patients have access to, and coverage for, essential hearing, dental, and
17 vision services. Some testimony noted that some of the resolve clauses of the original resolutions
18 did not align with the United States Preventive Task Services Task Force (USPSTF)
19 recommendations for hearing and vision screening for older adults. Further testimony stressed that
20 the expansion of health insurance coverage, and potentially Medicare benefits, for dental, vision,
21 and hearing services needs to be considered not only from the patient perspective, but within the
22 context of a Medicare payment infrastructure that is unsustainable for physician practices. In
23 response to concerns regarding how coverage for these services would be paid for, an amendment
24 was proffered to ensure that our AMA supports new Medicare funding that is independent of the
25 Medicare Physician Payment Schedule to pay for these services. However, the Reference
26 Committee noted in its report that expanding dental, vision, and hearing coverage would still
27 require “pay-fors” in the current Congressional environment, pitting these coverage expansions
28 against other AMA priorities that require funding. This referred clause was assigned by the Board
29 of Trustees to the Council on Medical Service for study.

30
31 The Council has developed reports on these topics in recent years. In 2015, the Council authored
32 CMS Report 6, “Hearing Aid Coverage” and concluded that a recommendation supporting adult
33 hearing aid coverage mandates would conflict with Policies H-185.964 and H-165.856, which
34 oppose new health benefit mandates unrelated to patient protections and which jeopardize coverage
35 to currently insured populations, and supports the principle that benefit mandates should be
36 minimized to allow markets to determine benefit packages and permit a wide choice of coverage

1 options. Given the policy, the Council did not recommend that the AMA support Medicare
 2 coverage for hearing aids.

3
 4 In 2019, the Council authored CMS Report 3, “Medicare Coverage for Dental Services” and
 5 concluded that the AMA should continue to explore opportunities to work with the American
 6 Dental Association (ADA) to improve access to dental care for Medicare beneficiaries, support
 7 initiatives to expand health services research on the effectiveness of expanded dental coverage in
 8 improving health and preventing disease in the Medicare population, explore optimal dental benefit
 9 plan designs to cost-effectively improve health and prevent disease in the Medicare population, and
 10 examine the impact of expanded dental coverage on health care costs and utilization.

11
 12 **BACKGROUND**

13
 14 The most recent enrollment data from the Centers for Medicare & Medicaid Services (CMS) show
 15 that over 65 million individuals are enrolled in Medicare. This includes 35 million individuals
 16 enrolled in traditional fee-for-service Medicare plans and a little over 30 million individuals
 17 enrolled in Medicare Advantage plans.¹ According to a 2019 Kaiser Family Foundation (KFF) poll,
 18 16 percent of Medicare beneficiaries reported they could not get access to dental, vision, or hearing
 19 care. These numbers were higher amongst those with low incomes, in poor health, and/or in
 20 communities of color.²

21
 22 Another 2019 KFF poll indicated that 90 percent of the American public supported expanding
 23 Medicare to include dental, hearing, and vision care as a “top” or “important” priority for
 24 Congress.³ However, recent attempts at passing legislation in Congress have not been successful. In
 25 2019, the House passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Title VI of
 26 this bill would have added new benefits for dental, vision, and hearing coverage under Medicare,
 27 such as dentures, glasses, hearing aids, and preventive services. The Congressional Budget Office
 28 (CBO) estimate for this bill was \$358 billion over the next ten years (\$238 billion for dental
 29 coverage, \$30 billion for vision coverage, and \$89 billion for hearing coverage).⁴ In 2021, H.R.
 30 4311, the Medicare Dental, Vision, and Hearing Benefit Act was introduced in the House and
 31 proposed repealing the statutory exclusion that restricts coverage of dental, vision, and hearing
 32 benefits, and expanding coverage to offer these services under Medicare Part B. Neither of these
 33 bills advanced out of Congress. In March 2023, Senators Bob Casey (D-PA) and Ben Cardin
 34 (D-MD) introduced a similar bill, S.842, The Medicare and Medicaid Dental, Vision, and Hearing
 35 Benefit Act. This bill would also repeal the statutory exclusion that restricts coverage of dental,
 36 vision, and hearing services and expand coverage to offer:

- 37 • Dental and oral care, including coverage of routine cleanings and exams, fillings and
 38 crowns, major services such as root canals and extractions, emergency dental care and
 39 other necessary services, and payment for both full and partial dentures.
- 40 • Vision care, including routine eye exams, procedures performed to determine the
 41 refractive states of the eyes and other necessary services, and payment for eyeglasses,
 42 contact lenses, and low-vision devices.
- 43 • Hearing care, including hearing exams, exams for hearing aids and other necessary
 44 services, and payment for hearing aids.

45 This bill also encourages states to provide these optional services to people with Medicaid by
 46 increasing the associated Federal Medical Assistance Percentage rate to 90 percent. At the time that
 47 this report was written, this bill was referred to the Senate Committee on Finance and the full text
 48 of the bill was not yet available.

1 DENTAL CARE AND COVERAGE

2
3 The medical-dental coverage divide first began in the 20th century. In the early 1900s, oral health
4 was widely thought to have little to no bearing on overall health and efforts to combine medical
5 and dental fields were opposed by dentists. In the 1920s, William Gies, a biological chemist,
6 insisted that oral health was directly related to overall health and recommended dentistry should be
7 integrated into the medical field, but dentists again resisted this change. During the 1940s and
8 1950s, the AMA and the ADA joined efforts to oppose health insurance nationalization and/or
9 expansion. During this same period, tap water fluoridation improved oral disease prevention among
10 Americans, which some believed mitigated the need for some dental services and reduced demand
11 for dental insurance coverage. Moreover, because dental service coverage began being widely
12 included in employer-sponsored benefit packages later than medical health service coverage, it was
13 considered a “perk” or cosmetic-only benefit, a perception that continues as dental care is still
14 regarded by many as auxiliary to general health care even though current research clearly
15 demonstrates the critical relationship between oral health and optimal overall health. When
16 Medicare legislation was passed in 1965, oral health coverage was not included. As a result, the
17 medical profession has frequently had to respond to the challenges of Medicare and Medicaid
18 coverage and changes in payment policy over the years, while dentistry has not.⁵

19
20 A statutory exclusion in Section 1862(a)(12) of the Social Security Act expressly prohibits
21 coverage for most dental services, specifically, “services in connection with the care, treatment,
22 filling, removal, or replacement of teeth or structures directly supporting teeth” by Medicare for its
23 beneficiaries.⁶ Therefore, traditional Medicare regulations do not include coverage for routine oral
24 health care including checkups, cleanings, and x-rays, or restorative procedures, tooth extraction,
25 and dentures. To integrate dental benefits in Medicare, Congress would need to remove this
26 exclusion, and add statutory changes, such as establishing the scope of dental services and a
27 mechanism for provider payment that is independent from the Medicare Physician Payment
28 Schedule.

29
30 As of 2018, almost half of Medicare beneficiaries did not have a dental visit within the past year
31 (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (63 percent),
32 have low incomes (73 percent), or who are in fair or poor health (63 percent). Nonetheless, 94
33 percent of Medicare Advantage enrollees in individual plans are in a plan that offers access to some
34 dental coverage. Nearly two-thirds of Medicare Advantage enrollees (64 percent) with access to
35 preventive benefits, such as oral exams, cleaning and/or x-rays, pay no cost sharing for these
36 services, though their coverage is typically limited to an annual dollar amount. Average
37 out-of-pocket spending on dental services among Medicare beneficiaries (both traditional
38 fee-for-service and Medicare Advantage) who had any dental service was \$872 in 2019. Those
39 enrolled in Medicare Advantage plans paid slightly less out-of-pocket than those enrolled in
40 traditional Medicare (\$729 vs. \$995).⁷ A February 2023 study published in *Health Affairs* found
41 substantial declines in dental service use and worsened health outcomes after individuals became
42 eligible for traditional Medicare at age 65. Additionally, this study found that there was also
43 evidence of lower dental service use by those beneficiaries who opted for a Medicare Advantage
44 plan and who likely have some coverage for these services. The authors suggest that benefit and
45 plan design should not only offer coverage of these services, but also address barriers to access to
46 necessary care beyond whether or not a beneficiary has coverage (i.e., out of pocket affordability
47 for co-pays/coinsurance, lack of familiarity with covered benefits, or inability to find local dentists
48 accepting Medicare or Medicare Advantage patients).⁸

49
50 Historically, Medicare has paid for dental services when they are integral and inextricably linked to
51 treating a beneficiary’s primary medical condition. However, the services Medicare paid for were

1 limited to those specified in sub-regulatory guidance, such as reconstruction of a ridge when
2 performed as a result of and at the same time as the surgical removal of a tumor; stabilization or
3 immobilization of teeth when done in connection with the reduction of a jaw fracture; extraction of
4 teeth to prepare the jaw for radiation treatment of neoplastic disease; dental splints only when used
5 in conjunction with medically necessary treatment of a medical condition; and dental services –
6 including both examination and treatment – prior to organ transplants, cardiac valve replacements,
7 and valvuloplasty.⁹ Beginning in 2023, CMS formally codified these existing services in
8 rulemaking and added additional services to the dental exclusion exception including dental
9 examination and treatment when performed prior to a cardiac valve replacement and valvuloplasty
10 or organ transplant procedures. In 2024, coverage will be expanded to include dental services to
11 eliminate infection prior to treatment for head and neck cancers.

12
13 Additionally, the new regulation establishes an annual process to review public input and clinical
14 evidence on other medical circumstances that may allow for payment of relevant dental services
15 under the same exception.¹⁰ Medical associations and their members are encouraged to participate
16 in this annual review process by submitting their comments.

17
18 ADA policy states that for the purpose of presenting potential legislation that includes dental
19 benefits for adults age 65 and over in a tax payer-funded public program such as, Medicaid,
20 Children’s Health Insurance Program (CHIP), privately administered Medicare or other federal or
21 state programs, the ADA supports a program that: 1) covers individuals under 300 percent FPL;
22 2) covers the range of services necessary to achieve and maintain oral health; 3) is primarily funded
23 by the federal government and not fully dependent on state budgets; 4) is adequately funded to
24 support an annually reviewed reimbursement rate such that at least 50 percent of dentists within
25 each geographic area receive their full fee to support access to care; 5) includes minimal and
26 reasonable administration requirements; and 6) allows freedom of choice for patients to seek care
27 from any dentist while continuing to receive the full program benefit.¹¹ The full text of the policy
28 can be found here: <https://www.ada.org/about/governance/current-policies#medicare>.

29 30 VISION CARE AND COVERAGE

31
32 Medicare Part B covers certain vision services including treatment for glaucoma, macular
33 degeneration, cataract surgery (if done using traditional surgical techniques or using lasers), annual
34 eye exams for diabetic retinopathy for patients with diabetes, and annual glaucoma tests for
35 patients at high risk for developing glaucoma. However, traditional Medicare does not typically
36 cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover
37 eyeglasses or contact lenses themselves, other than eyeglasses following cataract surgery or
38 corrective lenses if a patient has cataract surgery that implants an intraocular lens.^{12,13}

39
40 Beneficiaries typically spend significantly less on vision coverage compared to dental and hearing
41 services. Traditional Medicare does not generally cover routine eye exams. However, beneficiaries
42 can seek supplemental vision coverage from Medicare Advantage or other private insurance
43 coverage. As of 2021, 99 percent of Medicare Advantage enrollees have access to some vision
44 coverage. 93 percent of Medicare Advantage enrollees are in plans that provide access to both eye
45 exams and eyewear (contacts and/or eyeglasses). However, enrollees may be limited in terms of
46 frequency of obtaining certain covered services and may be subject to annual dollar limits.¹⁴

47
48 Another option for seniors to receive an eye exam and eye health services is through EyeCare
49 America, which connects eligible seniors 65 and older with local volunteer ophthalmologists who
50 provide a medical eye exam often at no cost out-of-pocket, and up to one year of follow-up care for
51 any condition diagnosed during the initial exam and for the physician services. To qualify, an

1 individual must be a U.S. citizen or legal resident, aged 65 or older, not belong to a Health
2 Maintenance Organization or have eye care benefits through the Veterans Affairs, and not have
3 seen an ophthalmologist in three or more years. Notably, EyeCare America does not directly cover
4 the cost of eyeglasses, but can provide information to patients on where to get help paying for
5 eyeglasses if they are needed.^{15,16}

6 7 HEARING CARE AND COVERAGE

8
9 When Medicare was enacted in 1965, it did not include any coverage for hearing aids. Hearing aids
10 were considered “not routinely needed and low in cost” and many Americans did not live long
11 enough to need them. Today, hearing loss affects one-third of adults over the age of 65 and has a
12 significant impact on health.¹⁷ Traditional Medicare does not cover hearing exams, hearing aids, or
13 aural rehabilitative services. Medicare Advantage charges additional premiums for hearing
14 coverage, with out-of-pocket costs and annual limits varying across plans. Traditional Medicare
15 covers medically reasonable and necessary hearing tests and treatments when ordered by a
16 physician or a non-physician practitioner including diagnostic services related to hearing loss that
17 is treated with surgically implanted hearing devices, and covers cochlear implants if a beneficiary
18 meets specific hearing loss criteria.¹⁸ Starting January 1, 2023 Medicare Part B expanded coverage
19 of audiology services to allow beneficiaries to receive care from an audiologist without a physician
20 or practitioner order once every 12 months for non-acute hearing assessments that are unrelated to
21 disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing
22 hearing aids.^{19,20,21} AMA policy supports coverage of hearing tests administered by a physician or a
23 physician-led team under Medicare’s benefit (H-185.929).

24
25 In 2021, the USPSTF reviewed the need to screen asymptomatic adults over the age of 50 for
26 hearing loss and concluded that the current evidence is insufficient to assess the balance of benefits
27 versus the harms of screening for hearing loss in older adults. The USPSTF also stated that
28 additional research was necessary.²²

29
30 In 2022, the Biden Administration issued an executive order for the Food and Drug Administration
31 (FDA) to allow over the counter (OTC) purchase of hearing aids for those with mild to moderate
32 hearing loss. OTC purchase of hearing aids became available in October 2022 and provides an
33 immediate, low-cost option for adults with mild to moderate hearing loss. OTC hearing aids range
34 in price from \$99 to \$3400 per pair and are readily available at local pharmacies, large retailers,
35 and online. By increasing competition among OTC hearing aid companies, the FDA rule is
36 designed to create more options for those who experience hearing loss and who want to purchase
37 affordable hearing aids.^{23,24}

38 39 MEDICARE PART B AND BUDGET NEUTRALITY

40
41 Medicare law requires that increases and decreases in payment rates by CMS must be budget
42 neutral – i.e., any changes resulting from regulatory changes made by CMS must have no impact
43 on total Medicare spending. Typically, this is done by lowering the Medicare “conversion factor.”
44 Increases in total Medicare spending are set by law. Unlike hospitals and nursing homes, Medicare
45 physician payments lack an automatic annual update. As a result, Medicare payments have failed to
46 keep pace with rising inflation.

47
48 The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that all new legislation changing
49 taxes, fees, or mandatory expenditures, when assessed together, must not increase projected
50 deficits. If legislation is enacted that cuts taxes or increases expenditures without fully offsetting
51 the cost, PAYGO applies a budget enforcement mechanism called sequestration. Sequestration is

1 the automatic reduction of certain types of spending in the federal budget, generally by a uniform
 2 percentage.^{25,26}

3
 4 If Congress adjourns at the end of a session with net costs on the Office of Management and
 5 Budget scorecard, the President is required to issue a sequestration order implementing across-the-
 6 board cuts to a select group of federal mandatory programs in an amount sufficient to offset the net
 7 costs. There are some exemptions from sequestration, such as Social Security, most unemployment
 8 benefits, interest on the national debt, federal retirement, and low-income entitlements (i.e.,
 9 Medicaid, Supplemental Nutrition Assistance Program, and Supplemental Security Income).
 10 However, the major remaining mandatory programs are subject to sequestration – including
 11 Medicare. If sequestration is ordered, each non-exempt mandatory program is reduced for one year
 12 by the same percentage, with one notable exception: Medicare payments subject to sequestration
 13 cannot be reduced by more than four percent. If sequestration would require a percent reduction
 14 greater than four percent, other non-exempt mandatory programs must make up the difference. To
 15 date, a sequester pursuant to PAYGO has not been applied, as Congress has either exempted
 16 legislation from PAYGO requirements or otherwise deferred the application of such
 17 requirements.²⁷

18
 19 POTENTIAL MEDICARE COVERAGE OPTIONS FOR DENTAL, VISION, AND HEARING
 20 SERVICES

21
 22 Expansion of Medicare coverage to new services has been considered and debated extensively.
 23 While many believe that Medicare beneficiaries should have coverage for a wider range of
 24 services, there are significant challenges to expanded coverage. Proponents of expanding Medicare
 25 coverage for dental, vision, and hearing services have suggested the following:

- 26
 27 • Congress could change the law to add dental, vision, and hearing coverage under
 28 traditional Medicare Part B. The benefits of this option are that it would impact all 65
 29 million Medicare beneficiaries and could lead to enhanced benefits that are integrated into
 30 other Medicare-covered services. The challenges facing this option include determining
 31 new claims systems and payment schedules that are independent of the Medicare Physician
 32 Payment Schedule. Perhaps the largest challenge to this approach is the price tag assigned
 33 by CBO: \$358 billion over the next ten years is an enormous sum, especially when the
 34 current level of inflation is added to this previous score. Another major challenge involves
 35 budget neutrality requirements. If these services were covered under Medicare Part B, the
 36 conversion factor would need to be significantly reduced to balance the increased
 37 spending, thereby reducing payment for other Medicare Part B services. Alternatively, if
 38 the conversion factor were to remain the same and the new funding was independent of the
 39 Medicare Physician Payment Schedule, the pool of money allotted for Medicare Part B
 40 would still have to increase substantially, which is also untenable. Under either of these
 41 scenarios, funding for this option would be diverted from another program and there is
 42 potential risk for competing federal priorities for the AMA (i.e., the AMA’s Recovery Plan
 43 for America’s Physicians).
 44
- 45 • Beneficiaries could enroll in Medicare Advantage (Part C) plans. Coverage for dental,
 46 vision, and hearing services under Medicare Advantage is already an option for most
 47 beneficiaries. These services are often offered through supplementary coverage under
 48 Medicare Advantage plans. Most Medicare Advantage enrollees are in plans that offer
 49 dental (96 percent), vision (99 percent), and hearing (98 percent) coverage. Medicare
 50 Advantage plans can vary, but most plans cover both preventive and extensive dental
 51 services, access to eye exams and eyewear (contacts and/or glasses), and hearing exams

1 and hearing aids. Medigap plans may also cover dental, vision, and hearing services to
2 supplement traditional Medicare coverage.
3

- 4 • A new, optional part of Medicare for dental, vision, and hearing coverage that would be
5 similar to Medicare Part D for prescription drug coverage could be created. Beneficiaries
6 would have the option to sign up, likely for an additional premium. While this new part
7 would not be subject to the specific budget neutrality requirements of adding coverage for
8 these services under Medicare Part B, the challenge of how to pay for this coverage still
9 remains. This solution could also further complicate the Medicare system and is largely
10 redundant for Medicare Advantage beneficiaries since the vast majority of Medicare
11 Advantage (Part C) plans already offer coverage for dental, vision, and hearing services for
12 an additional premium. Again, there is also the risk that advocacy for this option would be
13 in competition with other AMA priorities.
14
- 15 • A form of cash assistance or debit card for beneficiaries who do not have access to
16 coverage for dental, vision, and/or hearing services could be established. While this option
17 could be less costly than the others presented, there is still a funding challenge present.
18 Other outstanding questions include the amount of money offered to each beneficiary, the
19 impact on beneficiaries who already have some sort of supplemental coverage, and how
20 government officials would ensure this assistance was only being utilized for covered
21 services. More research would need to be completed before consideration of this option.
22

23 AMA POLICY

24
25 AMA Policy D-160.925 affirms the importance of oral health care. Policy H-330.872 affirms that
26 the AMA supports continued opportunities to work with the ADA and other interested national
27 organizations to improve access to dental care for Medicare beneficiaries. The policy goes on to
28 affirm AMA support for initiatives to expand health services research on the effectiveness of
29 expanded dental coverage in improving health and preventing disease in the Medicare population,
30 the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the
31 Medicare population, and the impact of expanded dental coverage on health care costs and
32 utilization.
33

34 Policy H-25.990 states that the AMA encourages the development of programs and/or outreach
35 efforts to support periodic eye examinations for elderly patients.
36

37 Policy H-185.929 states that the AMA encourages private health plans to offer optional riders that
38 allow their members to add hearing benefits to existing policies to offset the cost of hearing aid
39 purchases, hearing-related exams and related services; supports coverage of hearing tests
40 administered by a physician or physician-led team as part of Medicare's benefit; supports policies
41 that increase access to hearing aids and other technologies and services that alleviate hearing loss
42 and its consequences for the elderly; encourages increased transparency and access for hearing aid
43 technologies through itemization of audiologic service costs for hearing aids; and supports the
44 availability of over the counter hearing aids for the treatment of mild-to-moderate hearing loss.
45

46 Policy D-185.972, established with the adoption of Alternate Resolution 113-A-22, affirms that the
47 AMA will promote awareness of hearing impairment as a potential contributor to the development
48 of cognitive impairment or dementia later in life and encourage other stakeholders to promote the
49 conduct and acceleration of research into specific patterns of hearing loss to determine those most
50 linked to cognitive impairment or dementia and amenable to correction. The AMA will work with
51 interested national medical specialty societies and state medical associations to encourage and

1 promote research into hearing loss as a contributor to cognitive impairment, and to increase patient
2 access to hearing loss identification and remediation services; and promote research into vision and
3 dental health and to increase patient access to vision and dental services.

4
5 More broadly, Policy H-185.964 states that the AMA opposes new health benefit mandates
6 unrelated to patient protections, which jeopardize coverage to currently insured populations.
7 Additionally, Policy D-390.946 affirms that the AMA will work towards the elimination of budget
8 neutrality requirements within Medicare Part B; will eliminate, replace, or supplement budget
9 neutrality in Merit-based Incentive Payment System with positive incentive payments; and will
10 advocate strongly to the current administration and Congress that additional funds must be put into
11 the Medicare physician payment system to address increasing costs of physician practices, and that
12 continued budget neutrality is not an option.

13
14 Other related policies include D-330.935 and H-425.988, which state that the AMA will
15 collaborate with relevant stakeholders to actively promote the value of the Welcome to Medicare
16 Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services, as well as
17 work with the federal government and other stakeholders to support providing preventive service
18 coverage for seniors.

19
20 As part of its Recovery Plan for America’s Physicians, the AMA has dedicated an entire strategic
21 pillar to reforming the Medicare physician payment system. In February 2023, the AMA led nearly
22 100 organizations in asking Congress to explore long-term solutions to the Medicare physician
23 payment problems. The AMA is encouraging the 118th Congress to “work with us on long-term,
24 substantive payment reforms and urge congressional hearings as soon as possible to begin
25 exploring potential payment solutions to ensure America’s seniors continue to receive access to the
26 high-quality care they deserve.”²⁸

27 28 DISCUSSION

29
30 There are several aspects to consider when exploring ways to expand coverage for dental, vision,
31 and hearing services to Medicare beneficiaries, including cost, access, the current political
32 environment, the relevance of these services to overall health, existing AMA efforts to improve
33 Medicare payment to physicians, and the scope of the AMA’s influence.

34
35 Given the current rate of inflation, the \$358 billion projection from CBO in 2019 to include
36 coverage for dental, vision, and hearing services in the Medicare program over the next decade
37 would likely be substantially higher today. In an environment in which Medicare is subject to
38 statutory budget neutrality requirements, the Council believes it is impossible to consider this issue
39 in a vacuum and the AMA must acknowledge the likely impact that adding these services would
40 mean for payment and access to current health care services for Medicare beneficiaries. At the time
41 that this report was written, the bill recently introduced by Senators Casey and Cardin did not have
42 a CBO score nor was the full text of the bill available.

43
44 The Council acknowledges the potential value of expanded Medicare benefits. Nonetheless, dental,
45 vision, and hearing services already are frequently offered through supplementary coverage under
46 Medicare Advantage (Part C) or Medigap plans. Veterans can receive coverage for these services
47 through Veterans Health Administration (VHA) plans (including free hearing aids), and low-
48 income individuals can often receive coverage through Medicaid. Other beneficiaries have private
49 coverage offered through an employer or an individually purchased plan.

1 In terms of the current political environment, at the time that this report was written, Congress had
2 recently failed to prevent a budget neutrality cut to the Medicare physician conversion factor and
3 was facing a stalemate on how to move forward with managing the national debt. At a time when
4 physicians are already fighting to keep practices open amid continued payment cuts due to lack of
5 an annual inflation-based update, frozen Medicare payment rates under the Medicare Access and
6 CHIP Reauthorization Act, and budget neutrality restrictions, pursuing broader Medicare coverage
7 expansions would be extremely challenging. Enacting Medicare physician payment reform remains
8 one of the AMA's highest priorities under our Recovery Plan for America's Physicians.
9

10 The Council also reemphasizes the importance of working with the ADA when it comes to
11 strategies to expand dental coverage to Medicare beneficiaries. It is crucial for the ADA and the
12 AMA to work together to navigate the current policy landscape regarding infringements on the
13 Medicare Physician Payment Schedule. While the Council acknowledges that oral health care is a
14 critical part of overall health care, we believe that our dental colleagues are best positioned to
15 assess the payment structures that work best for their needs. Notably, in 2020, the ADA enacted
16 new policy to address dental coverage under Medicare. The AMA will continue to work closely
17 with the ADA to share data on oral health care's impact on overall health, as stated in AMA policy.
18

19 The Council believes that the AMA can be most influential in addressing the need for hearing
20 services through improving mechanisms already in place. Physicians should educate and encourage
21 their patients on lower cost hearing aids that are now available over the counter for mild to
22 moderate hearing loss. Additionally, the AMA can encourage the USPSTF to re-evaluate its
23 decision not to recommend screening for hearing loss in asymptomatic adults over age 65,
24 especially considering the new evidence that exists about the connection of hearing loss and
25 dementia. Hearing loss caught and treated early could prevent the onset of dementia and improve
26 quality of life for the aging population.
27

28 Finally, the Council believes that AMA policy on vision coverage could be strengthened, and we
29 recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for
30 affordable prescription eyeglasses.
31

32 RECOMMENDATIONS

33

34 The Council on Medical Service recommends that the following recommendations be adopted in
35 lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the
36 report be filed:
37

- 38 1. That our American Medical Association (AMA) support physician and patient education
39 on the proper role of over the counter hearing aids, including the value of physician-led
40 assessment of hearing loss, and when they are appropriate for patients and when there are
41 possible cost-savings. (New HOD Policy)
42
- 43 2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate
44 its determination not to recommend preventive hearing services and screenings in
45 asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss
46 to dementia. (New HOD Policy)
47
- 48 3. That our AMA amend Policy H-25.990 by addition to read as follows:
49

50 Our AMA (1) encourages the development of programs and/or outreach efforts to support
51 periodic eye examinations and access to affordable prescription eyeglasses for elderly

- 1 patients; and (2) encourages physicians to work with their state medical associations and
2 appropriate specialty societies to create statutes that uphold the interests of patients and
3 communities and that safeguard physicians from liability when reporting in good faith the
4 results of vision screenings. (Amend HOD Policy)
5
- 6 4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing
7 oral health and the importance of dental care to optimal patient care and supports the
8 exploration of opportunities for collaboration with the American Dental Association
9 (ADA) on comprehensive strategy for improving oral health care and education for
10 clinicians. (Reaffirm HOD Policy)
11
- 12 5. That our AMA reaffirm Policy H-330.872, which supports the American Medical
13 Association's continued work with the ADA to improve access to dental care for Medicare
14 beneficiaries and supports initiatives to expand health services research on the
15 effectiveness of expanded dental coverage in improving health and preventing disease in
16 the Medicare population, the optimal dental benefit plan designs to cost-effectively
17 improve health and prevent disease in the Medicare population, and the impact of
18 expanded dental coverage on health care costs and utilization. (Reaffirm HOD Policy)
19
- 20 6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests
21 administered by a physician or physician-led team as part of Medicare's benefit and
22 policies that increase access to hearing aids and other technologies and services that
23 alleviate hearing loss and its consequences for the elderly and supports the availability of
24 over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Reaffirm
25 HOD Policy)
26
- 27 7. That our AMA reaffirm Policy D-390.946, which supports the American Medical
28 Association's work towards the elimination of budget neutrality requirements within
29 Medicare Part B. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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APPENDIX

Policies Recommended for Amendment or Reaffirmation

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. (Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19)

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (CMS Rep. 03, A-19)

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15)

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (CMS Rep. 6, I-15; Appended: Res. 124, A-19)

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive

payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. (Res. 212, I-21; Reaffirmed: Res. 240, A-22)

REPORT 03 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Private Insurer Payment Integrity
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 110-A-22, which asked the American Medical Association to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as “experimental and/or investigational” when they are covered under government plans.

Private insurers may each make their own medical coverage determinations, which can vary across their product lines. Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment “investigational,” “experimental,” or “not medically necessary,” which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination.

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services. Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria. The NCD process is a transparent, nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment, which may include clinical studies. The supposition that private insurers’ medical coverage determinations are more restrictive than Medicare’s is not necessarily true and may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements.

While the Patient Protection and Affordable Care Act (ACA) establishes benefit mandates in the form of essential health benefits (EHB), private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged by decisions such as *Braidwood Management Inc. et al. v. Becerra et al.*

While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a need for transparency of coverage determinations, specifically regarding disparities across insurer product lines. The NCD process is very robust and might serve as a template for establishing a comprehensive, evidence-based process to allow for consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a diagnosis and treatment option as “experimental/investigational” in order not to have to pay for it.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 03-A-23

Subject: Private Insurer Payment Integrity
(Resolution 110-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

1 At the June 2022 Annual Meeting, the House of Delegates referred Resolution 110, which was
2 sponsored by the New York Delegation. Resolution 110-A-22 asked the American Medical
3 Association (AMA) to advocate for private insurers to require, at a minimum, to pay for diagnosis
4 and treatment options that are covered by government payers such as Medicare and seek legislation
5 or regulation to ensure that private insurers shall not be allowed to deny payment for treatment
6 options as “experimental and/or investigational” when they are covered under government plans.
7 Testimony at the June 2022 Annual Meeting regarding the resolution was generally opposed,
8 highlighting the complex issues surrounding private insurer versus governmental coverage,
9 specifically regarding benefit mandates and the differential drivers utilized in making medical
10 coverage determinations. This report focuses on the need for transparency of medical coverage
11 determinations, studies how ‘investigational’ diagnosis and treatment options are determined,
12 highlights essential AMA policy, and presents new policy recommendations.

13

14 BACKGROUND

15

16 Coverage Determinations by Private Insurers

17

18 Private insurers are a fragmented group of commercial plans operating under a broad range of
19 federal regulations as well as insurance and coverage rules and regulations that vary by state. Some
20 private insurers operate nationally. While they may look to governmental precedent in certain
21 situations, they each make their own medical coverage determinations, which can vary across their
22 product lines. Access to private insurers’ medical coverage decisions is limited, but not entirely
23 restricted. For example, on the UnitedHealthcare (UHC) web site, the UHC commercial policy on
24 coverage of “Off-Label/Unproven Specialty Drug Treatment” includes a Food & Drug
25 Administration (FDA) section, noting that it is “to be used for informational purposes only...FDA
26 approval alone is not a basis for coverage.”

27

28 Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment
29 “investigational,” “experimental,” or “not medically necessary,” which may be exacerbated by the
30 burdensome appeals process required to request reconsideration of a denial or adverse
31 determination. Patients are typically not aware of their right to appeal or legal due process
32 protections. This health insurance illiteracy is compounded among patients with limited access to
33 technology and other resources, leading to the potential for substantial health inequities across
34 private plans.

1 Coverage Determinations by the Centers for Medicare & Medicaid Services

2
3 Of government payers, Medicare is typically considered the national benchmark, particularly since
4 it is a federal defined benefit program, with decisions centralized within the Centers for Medicare
5 & Medicaid Services (CMS). Title XVIII of the Social Security Act established Medicare with
6 coverage that is limited to items and services that are:

- 7
8 • reasonable and necessary for the diagnosis or treatment of an illness or injury; and
9 • within the scope of a Medicare defined benefit category.

10
11 *National Coverage Determinations*

12
13 The vast majority of Medicare coverage is determined on the local level by clinician contractors
14 (Medicare Administrative Contractors [MACs] making Local Coverage Determinations [LCDs]).
15 However, in some cases, Medicare develops National Coverage Determinations (NCDs) that are
16 applied for all Medicare beneficiaries meeting the coverage criteria.

17
18 The NCD process is a nine-month, evidence-based process with opportunities for public comment
19 and supplemental technological assessment by the Medicare Evidence Development & Coverage
20 Advisory Committee (MEDCAC), which may include clinical studies. If the NCD determines
21 coverage of an item or service only in the context of clinical study, it falls under the Coverage with
22 Evidence Development (CED) program. NCDs in the CED program use available evidence to fit
23 that item or service within that benefit category. As such, CMS can act as a coverage gatekeeper
24 via the NCD process. This mechanism has been used over the past few decades and includes
25 evidence-based guidelines for coverage.

26
27 Since it has been nearly eight years since the criteria for CED were last evaluated, MEDCAC is
28 currently re-examining the requirements for clinical studies submitted for CMS coverage under
29 CED, acknowledging that the update is needed since technologies have become more complex.
30 MEDCAC also has conveyed “a commitment to greater transparency in decision-making, to
31 making certain that study methodologies are ‘fit to purpose’ as determined by the topic, questions
32 asked, health outcomes studied, and to making certain that the populations studied are
33 representative of the diversity in the Medicare beneficiary population.”¹

34
35 The NCD process has been amended on several occasions (e.g., The Medicare Prescription Drug,
36 Improvement, and Modernization Act of 2003), with updates made to the process for opening,
37 deciding, or reconsidering NCDs under the Social Security Act. The 2013 update developed an
38 expedited administrative process utilizing specific criteria to remove certain NCDs older than ten
39 years, thereby enabling MACs to determine coverage under the Social Security Act for sunset
40 NCDs. For 2023, CMS has updated Medicare coverage policies for colorectal cancer screening in
41 order to align with recent United States Preventive Services Task Force (USPSTF) and national
42 medical specialty society recommendations.²

43
44 Transparency is a keystone to the process, as CMS issues an annual report listing the NCDs made
45 in the previous calendar year in the form of a report to Congress. Additionally, there is an NCD
46 dashboard, outlining the status of NCDs at each stage of the process (i.e., under review, reviewed
47 but not yet opened, opened and undergoing national coverage analysis, and finalized). CMS houses
48 all Medicare coverage determinations in the Medicare Coverage Database (MCD). The MCD
49 includes LCDs as well as NCDs, along with reports on each.

1 The supposition that private insurers' medical coverage determinations are more restrictive than
2 Medicare's may be based on the perception that traditional Medicare fee-for-service coverage is
3 more robust due to its paucity of prior authorization requirements. Data indicates otherwise, such
4 as with NCDs for medical devices. For each of the 47 medical devices considered for NCDs
5 between February 1999 and August 2013, it was found that NCDs were equivalent to the
6 corresponding private insurer policies roughly half of the time, more restrictive approximately a
7 quarter of the time, and less restrictive about a quarter of the time.³

8
9 *Food and Drug Administration*

10
11 The notion that Medicare "adopts" diagnostic and treatment options once approved by the FDA is
12 similarly problematic. Medicare does not automatically cover all FDA-approved devices and drugs.
13 Between 1999 and 2011, Medicare covered FDA-approved drugs or devices only 80 percent of the
14 time.⁴ Additionally, Medicare has been found to have more stringent requirements than the FDA,
15 particularly for drugs or devices in patients with comorbidities.

16
17 The Medicare Benefit Policy Manual (Chapter 14 – Medical Devices) outlines that Medicare will
18 cover FDA-approved and Institutional Review Board (IRB)-approved investigational devices
19 "provided the investigational device meets certain requirements, including: (1) The device or
20 services associated with the use of a device are provided to the beneficiary within the start and end
21 dates contained in the master file; (2) There are no regulations, national coverage policies, or
22 manual instructions that would otherwise prohibit Medicare coverage."

23
24 *Medicare Investigational Device Exemption*

25
26 While Medicare normally does not cover experimental or investigational procedures, it does offer
27 an exemption for investigational devices to allow for coverage under some circumstances. The
28 Medicare Investigational Device Exemption (IDE) was developed as part of the Medicare
29 Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and includes two
30 categories:

- 31
- 32 • Category A (Experimental): An innovative/experimental device for which "absolute risk"
33 of the device type has not been established (i.e., initial questions of safety and effectiveness
34 have not been resolved and the FDA is unsure whether the device type can be safe and
35 effective). There is no Medicare coverage for a Category A device but Medicare covers
36 routine care items and services in the trial. An example is the [CG-100 Intraluminal ByPass
37 Device](#).
 - 38 • Category B (Non-experimental/non-investigational): A device for which the underlying
39 questions of safety and effectiveness of that device type have been resolved. Medicare
40 allows for coverage of the Category B device as well as for routine care items and services
41 in the trial. An example is the [Viper Catheter System](#).
- 42

43 In 2015, CMS shifted responsibility for review and approval of IDE studies from the MACs to a
44 centralized CMS process, which includes a publicly accessible, updated list of Approved IDE
45 Studies.

46
47 *Medicare Coverage of Innovative Technology and Definition of Reasonable and Necessary*

48
49 In January 2021, CMS released a final rule on The Medicare Coverage of Innovative Technology
50 and Definition of "Reasonable and Necessary,"⁵ which established pathways to payment for
51 innovative technologies supported by high-quality, validated clinical data. The rule automatically

1 provided four years of coverage for all Medicare beneficiaries for newly approved medical devices,
 2 in order to accelerate availability of medical devices approved through the FDA breakthrough
 3 pathway for innovative technologies.

4
 5 As part of the rule, CMS proposed automatically transferring the coverage policy of commercial
 6 insurance to Medicare beneficiaries for new products. In two identical comment letters (November
 7 2020 and April 2021), the AMA outlined several concerns with the proposal, namely the potential
 8 loss of transparency in Medicare coverage decisions if tied to commercial health insurer policies
 9 beholden to shareholder expectations. The independent, public comment process utilized by CMS
 10 to make coverage decisions appropriate for the Medicare population would be replaced with
 11 coverage decisions based on objectives such as litigation avoidance or competitive advantage. The
 12 AMA argued that the focus should remain on what is most suitable and safest for Medicare
 13 beneficiaries based on Medicare’s determination.

14
 15 After considering these and other comments, CMS rescinded the rule in November 2021, citing
 16 concerns about lack of sufficient patient protections and lack of evidence of clinical benefit for the
 17 newly approved medical devices in the Medicare population. At the present time, CMS is working
 18 on a new proposed rule to create an accelerated Medicare coverage pathway, building on prior
 19 initiatives such as CED.⁶

20
 21 AFFORDABLE CARE ACT BENEFIT MANDATES

22
 23 The Patient Protection and Affordable Care Act (ACA) requires non-grandfathered health plans in
 24 the individual and small group markets to cover the following essential health benefits (EHB): (1)
 25 ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn
 26 care; (5) mental health and substance use disorder services including behavioral health treatment;
 27 (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory
 28 services; (9) preventive and wellness services and chronic disease management; and (10) pediatric
 29 services, including oral and vision care. The Department of Health and Human Services (HHS)
 30 regulations define EHB using state-specific benchmarks. Since 2020, states have been granted
 31 greater flexibility in establishing new standards for their EHB benchmark plans. Non-grandfathered
 32 health plans cannot refuse coverage or limit benefits for pre-existing conditions.

33
 34 Since the passage of the ACA in 2010, there have been more than 2,000 state and federal actions
 35 attempting to limit, alter, or repeal it.⁷ Most recently, in *Braidwood Management Inc. et al. v.*
 36 *Becerra et al.*, a federal judge ruled that insurers are no longer required to provide preventive
 37 services recommended by USPSTF at no cost. While some states have challenged parts or all of the
 38 ACA through legislation, others have acted to preserve the ACA by codifying certain provisions
 39 into state law.

40
 41 Private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB
 42 benefit mandate, even as it continues to be challenged. For example, while insurers were initially
 43 required to cover preexposure prophylaxis (PrEP), a medication that prevents the transmission of
 44 human immunodeficiency virus in high-risk populations (e.g., gay and bisexual men of color)
 45 without cost sharing, not all insurers extended the benefit to the ancillary services (e.g.,
 46 venipuncture, office visits) required to provide PrEP. HHS had to issue subsequent guidance to
 47 clarify that insurers were required to cover PrEP ancillary services under their EHBs. As decisions
 48 such as *Braidwood Management Inc. et al. v. Becerra et al.*, erode the ACA EHB benefit mandate,
 49 it will become increasingly important that private ACA marketplace insurers are held accountable
 50 for covering all current ACA EHB benefit mandates.

1 AMA POLICY

2
3 The AMA’s longstanding goals to allow markets to determine benefit packages in order to permit a
4 wide choice of coverage options and to refrain from jeopardizing coverage to currently insured
5 populations are reflected in numerous AMA policies as well as in the AMA Proposal for Reform,
6 which is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice,
7 and universal access for patients. AMA policy supports the minimization of benefit mandates to
8 allow markets to determine benefit packages, permitting a wide choice of coverage options.

9
10 Among the most relevant policies are those that:

- 11
- 12 • Oppose new health benefit mandates unrelated to patient protections (Policy H-185.964);
 - 13 • Advocate for the minimization of benefit mandates (Policy H-165.856);
 - 14 • Support maximization of patient choice (Policy H-165.839) and free market choice of
15 plans (Policy H-330.912);
 - 16 • Encourage payers to utilize transparent and accountable processes for developing and
17 implementing coverage decisions and policies (Policy D-185.986);
 - 18 • Assure reasonable payment levels for mandated benefits in health insurance policies
19 (Policy D-385.966); and
 - 20 • Call for the AMA to develop model legislation and/or regulations to require that
21 commercial insurance companies, state Medicaid agencies, or other third party payers
22 utilize transparent and accountable processes for developing and implementing coverage
23 decisions and policies (Policy D-185.986).
- 24

25 While AMA policy opposes blanket benefit mandates, there is policy on coverage of specific
26 conditions and services. For example, Policy H-185.967 supports that treatment of pediatric
27 congenital or developmental deformities or disorders due to trauma or malignant disease should be
28 covered by all insurers, Policy H-185.957 supports legislation that requires all third party payers
29 that cover surgical benefits to cover all strabismus surgery where medically indicated, and Policy
30 D-185.973 encourages insurance coverage of and payment for reconstructive services for the
31 treatment of physical injury sustained from intimate partner violence. The AMA defended Policy
32 D-185.979 by filing an [amicus brief](#) in *Braidwood Management Inc. et al. v. Becerra et al.*, which
33 challenged support for first dollar coverage of preventive services.

34
35 The AMA definition of “medical necessity” (Policy H-320.953), urges payers to share third party
36 methodologies for determining medical necessity, and advocates for the opportunity for treating
37 physicians to provide medical evidence toward those determinations (Policy H-320.995). The
38 AMA’s definition of medical necessity is included in state model legislation and has been enacted
39 in several states as a required definition, rather than allowing plans to develop their own
40 definitions. Policies H-320.968 and H-320.982 support that denial of medical necessity of services
41 or request for prior authorization be recommended by a physician of the same specialty as the
42 treating physician.

43
44 Finally, there is AMA policy to protect patients and physicians and encourage innovation in the
45 context of experimental or investigational treatments. Policy D-460.967 calls for the AMA to study
46 the implementation of expanded access programs, accelerated approval mechanisms, and payment
47 reform models to increase access to investigational therapies. Policy H-460.965 states that the
48 AMA should pursue legislation and regulatory reform to mandate third party payer coverage of
49 patient care costs of nationally approved scientifically based research protocols. Policy H-480.996
50 supports that regulations be promulgated or interpreted so as to not interfere with the

1 patient/physician relationship or impose regulatory burdens that may discourage creativity and
2 innovation in advancing device technology.

3
4 DISCUSSION

5
6 While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a
7 need for transparency of coverage determinations, specifically regarding disparities across insurer
8 product lines. An insurer may cover something considered preventive under one product line yet
9 fail to cover the same thing under another product line. Such arbitrary coverage decisions not only
10 question payer integrity but also introduce superfluous physician administrative burdens, such as
11 prior authorization requirements.

12
13 While the AMA advocates for market-based solutions for coverage, there is presently a floor of
14 benefits nationally as ACA plans must cover certain conditions. ACA coverage decisions for non-
15 elective care at a basic level is necessary so that essential care is not determined by a patient's
16 socioeconomic status. While it would be helpful for private and governmental insurers to be
17 cognizant of each other's coverage decisions, it may not be ideal for them to be perfectly aligned
18 given that Medicare is sometimes more restrictive and sometimes less restrictive. However, to
19 encourage innovation, the process for gaining coverage must be transparent and expeditious. It
20 would be beneficial to continue to expand the ability of CMS to proactively engage coverage of
21 breakthrough therapies and devices at product launch – rather than having to wait for an NCD to be
22 established. When CMS requires additional studies prior to coverage, this feedback should ideally
23 be provided during the product development phase, not after the product is approved and available
24 to the public, when finding patients to enroll in trials is more difficult.

25
26 The NCD process is very robust and might serve as a template for establishing a comprehensive,
27 evidence-based process to allow for consistency in determinations of experimental/investigational
28 status and transparency in coverage determinations from which insurers can develop benefit
29 packages. The process could include online tools to allow physicians to easily check coverage
30 status rather than requiring completion of a prior authorization form and waiting for a response.
31 Implementation of such a process would not preclude private insurers from offering additional or
32 alternative benefits that would distinguish their products in the marketplace, allowing for a wide
33 choice of coverage options in keeping with AMA policy. In following established precedents, it
34 may amend the base level for what is considered medically necessary care (e.g., USPSTF grade A
35 or B recommendations are covered without cost-sharing under the ACA).

36
37 Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a
38 diagnosis and treatment option as “experimental/investigational” in order not to have to cover it.
39 There is considerable variation in how “experimental/investigational” diagnosis and treatment
40 options are determined, which only escalates concerns regarding subjective and inequitable
41 decisions. While some insurers may define experimental/investigational services as an intervention
42 that has not yet been determined to be medically effective for the condition being treated, others
43 describe it as something that has undergone basic laboratory testing and received approval from the
44 FDA to be tested in human subjects. The definition of experimental/investigational is a continuum
45 rather than a standard as it is contingent upon discrete, independent evaluations that vary from
46 insurer to insurer. While insurers may profess applying reasonable interpretation of their policy
47 provisions, those are also variable and lacking a standard.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 110-A-22, and the remainder of the report be filed:

- 5
6 1. That our American Medical Association (AMA) support the development of a
7 comprehensive, evidence-based process to establish consistency in determinations of
8 experimental/investigational status and transparency in coverage determinations from
9 which insurers can develop benefit packages. (New HOD Policy)
10
11 2. That our AMA support voluntary programs that expedite review for coverage by private
12 and governmental insurers when requested by either the manufacturer or third parties such
13 as national medical specialty societies. (New HOD Policy)
14
15 3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows:
16 4. Our AMA will advocate that when clinical coverage protocols are more restrictive than
17 governmental payers, that private insurers and benefit managers should include the clinical
18 rationale substantiating their coverage policies. (Modify Current HOD Policy)
19
20 4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates
21 unrelated to patient protections.(Reaffirm HOD Policy)
22
23 5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit
24 mandates. (Reaffirm HOD Policy)
25
26 6. That our AMA reaffirm Policy H-320.995, which urges payers to share third party
27 methodologies for determining “medical necessity,” and advocates for the opportunity for
28 treating physicians to provide medical evidence toward those determinations. (Reaffirm
29 HOD Policy)
30
31 7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of
32 expanded access programs, accelerated approval mechanisms, and payment reform models
33 to increase access to investigational therapies. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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REPORT 04 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Council’s review of the literature on select Medicare bundled payment models and Medicaid episodes of care found that lower extremity joint replacement (LEJR) bundles, and some perinatal episodes of care, have produced the most—but still modest—savings without compromising care quality. Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on skilled nursing and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including institutional post-acute care, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures, are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on alternative payment models (APMs), we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments.

To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs. The Council believes that well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-A-23

Subject: Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which was
2 cosponsored by the American Academy of Physical Medicine and Rehabilitation and the Ohio
3 delegations. Resolution 111-A-22 asked the American Medical Association (AMA) to 1) advocate
4 that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not
5 incentivize limiting medically necessary services for patients to allow better reimbursement for
6 recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary
7 care with a report back to explore the unintended long-term consequences on health care
8 expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional
9 improvement be a key target outcome for bundled payments.

10
11 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the
12 House of Delegates. This report adds to the body of reports developed by the Council on alternative
13 payment models (APMs) by providing background information specific to bundled/episode-based
14 payment models, summarizing the literature on prominent Medicare and Medicaid models,
15 reviewing relevant AMA policy and advocacy, and making policy recommendations.

16
17 **BACKGROUND**

18
19 Bundled or episode-based payments are a type of APM in which a single comprehensive payment
20 amount covers services delivered by multiple providers during an episode of care. An episode of
21 care is the care delivery process for a certain condition or procedure delivered within a defined
22 period of time. State Medicaid programs use the term episodes of care to describe payment models
23 in which a single bundled payment is made for services associated with the treatment of a condition
24 or procedure. The models aim to lessen variations in cost and quality by incentivizing providers
25 (e.g., physicians, hospitals, post-acute care facilities, and others providing services during the
26 episode) to work together and manage costs without compromising care quality. Providers able to
27 keep costs below a risk-adjusted target price for an episode may share in any savings and,
28 conversely, those exceeding that threshold may incur financial penalties. Savings can be generated
29 if, as is often the case, the target price is a discount of what has historically been paid, or if lower-
30 cost facilities and providers are utilized during the episode. To guard against underserving patients,
31 some models impose limits on gainsharing payments and/or require that certain quality metrics be
32 met.

33
34 Medicare, state Medicaid programs, and many private insurers have adopted bundled or episode-
35 based payment models to varying degrees with perinatal and joint replacement models increasingly
36 prevalent across multiple payers. Although Medicare has administered bundled payments for many
37 years, provisions in the Affordable Care Act (ACA) accelerated their use, along with other APMs,

1 by establishing the Center for Medicare & Medicaid Innovation (CMMI) and authorizing it to
2 develop and test new payment models without the need for Congressional approval. In 2015, the
3 Department of Health and Human Services announced national goals for transitioning to value-
4 based medicine and APMs; the same year, Congress passed the Medicare Access and CHIP
5 Reauthorization Act (MACRA), which among other things established incentive payments for
6 physicians to participate in advanced APMs. Centers for Medicare & Medicaid Services (CMS)
7 and a handful of states continue to experiment with episode-based payment approaches, such as
8 lengthier and more inclusive episodes and those that span multiple providers and/or sites of service.
9 Importantly, there is substantial variance among bundled/episode payment designs, with larger and
10 more widely implemented models including Medicare’s Bundled Payments for Care Improvement
11 (BPCI) Advanced initiative and the Comprehensive Care for Joint Replacement (CJR) model.
12

13 Medicare bundles have informed some Medicaid episodes of care although states have generally
14 adapted APMs to suit the unique needs of their Medicaid enrollees and health care in their states.¹
15 Notably, state Medicaid programs and Medicaid providers are at various stages of implementation
16 of value-based payment reforms and, to address ongoing budget pressures, many states have
17 pursued APMs to reduce cost growth in Medicaid while improving care quality. Because 70
18 percent of Medicaid enrollees are enrolled in managed care,² states often use contracting strategies
19 with managed care organizations (MCOs) to leverage the use of value-based payments, including
20 episodes of care. For example, more than half of states (20 of 37) that contract with MCOs to
21 manage care delivered to Medicaid enrollees require those plans to make a certain percentage of
22 provider payments through APMs, while some states require MCOs to adopt specific models.
23 Several states use financial incentives—and/or penalties—to compel MCOs to pursue value-based
24 payment models. To date, the use of episode-based payments has generally been limited to those
25 states that prescriptively define and require such models, including for joint replacement and
26 perinatal episodes of care.³ In a 2021 Kaiser Family Foundation survey, eight states (CO, NM, NY,
27 OH, PA, TN, VT, and VA) reported implementing episodes of care in Medicaid, although this
28 number changes as states implement new models while sunseting others.⁴
29

30 Most, but not all, bundled payment models are voluntary; the CJR initiative, which is mandatory in
31 certain areas and voluntary in others, and Medicaid models in some states, are exceptions. Beyond
32 that, bundled payment initiatives differ from each other in terms of duration, payment rules, and the
33 types of services included. Episodes can range from shorter durations to lengthier periods, as for
34 perinatal models that span the prenatal through postpartum periods. Although payments for
35 episodes of care can be determined prospectively or based on fee-for-service with retrospective
36 adjustments, most of the models discussed in this report adjust payments retrospectively.
37 Additionally, add-on payments covering high-cost or outlier cases may be made available to
38 varying degrees, depending on the model design. With respect to outliers, Policy H-385.907
39 advocates that bundled payments should recognize the differences in patients’ needs and payment
40 amounts should be risk stratified to reflect patients who need more resource-intensive services. The
41 menu of services paid for in a bundle also varies significantly across models and affects the types
42 of providers that participate. Notably, the CJR model includes most Part A and Part B services,
43 except for hospice and a few other carve-outs, while other models pay for a narrower set of
44 services.
45

46 Physician participation in bundled payment models has increased steadily over the past decade, as
47 evidenced by data from the AMA’s Physician Practice Benchmark Surveys, which are nationally
48 representative samples of non-federal physicians who provide care to patients at least 20
49 hours per week. According to recent Benchmark surveys, 32.0 percent of physicians were in
50 practices involved in bundled payments in 2012. This increased to 34.8 percent in 2016 and topped
51 40 percent in 2020 and 2022 for a cumulative increase of eight percentage points. Additionally, in

1 2022, an average of 10 percent of practice revenue (at the physician level) came from bundled
2 payments.⁵

3
4 The main obstacles to effective bundled payments are accurately defining care episodes, pricing the
5 bundles, and ensuring adequate payment for care provided by all team members across all sites of
6 service. Physicians have expressed concerns regarding both the financial arrangements and
7 administrative burdens incurred, including the degree of financial risk required to participate, the
8 potential for financial strain if the fixed payment amount does not accurately reflect the costs of the
9 episode, the potential for decreased payments, and administrative hurdles, especially when
10 participating in more than one APM. Additional concerns include high dropout rates among
11 hospitals participating in some models, the potential for some models to become mandatory, and
12 the ability of small physician practices to participate. In the Whereas clauses, the authors of
13 Resolution 111-A-22 highlighted concerns about the occurrence of unrelated—and costly—events
14 during a care episode, increased expenses for complex patients, the need for skilled nursing care by
15 some patients, and possible incentives to lessen costs by decreasing patient access to services they
16 may need.

17
18 Defining what is related and unrelated to a bundle can be problematic with episode models, yet
19 decisions about covered services are critical to ensuring appropriate payment. Care for unrelated
20 conditions and procedures that takes place within the duration of an episode can be costly and
21 potentially increase spending beyond the target price of the bundle. Importantly, the AMA
22 maintains that APMs should be designed by physicians or with significant input from physicians in
23 part so they can influence decisions about covered services and advocate that care for unrelated
24 events (e.g., cataract surgery during a 90-day lower extremity joint replacement (LEJR) episode)
25 not be paid for out of the bundled payment. The AMA also advocates that financial risk
26 requirements be limited to costs that physicians participating in an APM are able to influence or
27 control.

28
29 An additional shortcoming of many of the larger Medicare bundled payment models is that they
30 start with a hospitalization for a procedure. If, for example, episodes began with an evaluation for
31 hip, knee, or back pain, or other condition, there would be more opportunities to save money and
32 improve quality by, for example, engaging in patient-physician shared decision making strategies
33 that could potentially prevent hospitalizations and procedures altogether. Specific to Medicaid,
34 staffing, resource, and leadership capacity to develop and implement new models can be major
35 obstacles to implementing payment initiatives and, for this reason, state Medicaid directors have
36 asked CMS to provide upfront resources for states to engage in delivery system and payment
37 reforms.⁶ Additionally, risk thresholds may dissuade some Medicaid providers, especially those
38 practicing in states with particularly low payment rates, from participating in episode-based
39 payment models if they feel they cannot take on financial risk. Importantly, Medicaid enrollees
40 may have complex care needs and/or experience inequities in social determinants of health—such
41 as housing instability, food insecurity, or lack of transportation—that impact their care and health
42 outcomes. They also face unique barriers to care and may churn in and out of Medicaid, which
43 could lead some Medicaid providers to believe they will be disproportionately penalized under
44 APMs without sufficient risk adjustment.

45
46 Many of these obstacles have been addressed in previous reports and policy development by the
47 Council on Medical Service. [Council on Medical Service Report 9-A-16](#) established foundational
48 policy on physician-focused APMs while [Council on Medical Service Report 10-A-17](#) focused on
49 reducing some of the barriers to participating in these models and the need for changes to risk
50 adjustment systems, attribution methods, and performance target setting. AMA policy established
51 by [Council on Medical Service Report 10-A-19](#) addressed concerns raised by many that physicians

1 serving people who are sicker or experiencing poverty are disproportionately penalized by APMs.
2 [Council on Medical Service Report 3-I-19](#) established new policy on improving risk adjustment in
3 APMs, including that risk stratification systems should use fair and accurate payments based on
4 patient characteristics, and that risk adjustment systems should use fair and accurate outlier
5 payments if spending on an individual patient exceeds a predefined threshold. Concerns about
6 APMs, and AMA advocacy to improve upon value-based payment models, were also discussed in
7 [Council on Medical Service Report 2-A-22](#), which focused on prospective payment model best
8 practices for independent private practice.
9

10 EVIDENCE OF EFFECTIVENESS

11 *Select Medicare Bundled Payment Models*

12
13
14 Bundled/episode-based payments have been implemented for numerous surgical procedures and
15 medical conditions and remain a leading value-based payment reform in Medicare. Lacking the
16 capacity to thoroughly study the impact of all Medicare bundled payment models implemented
17 over the years, the Council reviewed independent evaluations of the larger CMS initiatives and
18 more recent analyses in the literature examining the impact of multiple bundles on Medicare
19 spending, quality of care, and unintended consequences. Information on a unique episode program
20 for non-hospital physicians developed as part of Maryland's statewide CMMI initiative is also
21 provided.
22

23 *BPCI*: One of the largest Medicare models was the voluntary BPCI initiative—four model designs
24 that offered episode-based payments to over 1,000 hospitals, physicians, and post-acute care
25 providers for 48 different clinical episodes over five years (2013-2018).⁷ Consistent with previous
26 findings, the final BPCI evaluation showed that the initiative reduced Medicare spending per
27 episode due primarily to declines in institutional post-acute care utilization and decreases in the
28 number of skilled nursing facility (SNF) days for those that needed SNF care. However, after
29 accounting for reconciliation payments to eligible providers, BPCI did not increase net Medicare
30 savings; instead, the initiative resulted in net increased Medicare spending beyond what it was
31 estimated to be in absence of the model.⁸ Evaluations further demonstrated that BPCI generally did
32 not affect quality of care as measured by emergency department visits, mortality, and hospital
33 readmissions. The evidence was mixed and included both positive and negative associations
34 between BPCI models and patient functioning,⁹ and fewer BPCI patients reported the highest level
35 of satisfaction with their care.¹⁰ Importantly, two studies analyzing outcomes of high-risk patients
36 found that participation in BPCI did not adversely impact their quality of care.^{11,12}
37

38 *BPCI Advanced*: Building on the experiences and lessons learned from BPCI, the BPCI Advanced
39 initiative—which includes bundles with one risk track and a 90-day duration—was launched in
40 2018 and has been extended to run through 2025. BPCI Advanced links performance on select
41 quality metrics to incentive payments and qualifies as an Advanced APM. Accordingly,
42 participating physicians who meet certain cost thresholds may be eligible for a five percent APM
43 incentive payment. Participation in BPCI Advanced is currently voluntary and notably widespread,
44 with 1,295 hospitals and physician groups participating in years one and two (2018 and 2019) and
45 more than 2,000 participating in year three (2020).¹³ CMS continues to use results from its
46 independent evaluations to refine the initiative, which reduced episode payments overall in 2018
47 and 2019 and produced greater savings (\$1,353 per episode) for surgical episodes than for medical
48 episodes (\$564 per episode).¹⁴ After accounting for reconciliation payments made to BPCI
49 Advanced providers in 2018 and 2019, the independent evaluator found that the initiative resulted
50 in net Medicare savings for surgical episodes and net increased Medicare spending for medical
51 episodes with an overall increase in Medicare spending of \$65.7 million.¹⁵ Consistent with BPCI

1 and other bundles, episode savings were primarily attributed to lower payments to post-acute care
2 sites, including SNFs and inpatient rehabilitation facilities. Importantly, quality of care was not
3 adversely impacted; in fact, BPCI Advanced has been found by the evaluators to reduce
4 readmissions for surgical episodes and to not worsen mortality rates.¹⁶ A separate study of BPCI
5 Advanced, published in 2022, also found the initiative to be associated with a net increase in
6 Medicare spending because bonuses paid to eligible hospitals exceeded episode payment
7 reductions.¹⁷ This study further found that hospitals caring for historically marginalized
8 populations received large bonuses under BPCI Advanced, possibly due to initial episode target
9 pricing, which was subsequently adjusted by CMS.¹⁸

10
11 *CJR*: The CJR model pays for care episodes that extend through 90 days after discharge from both
12 inpatient and outpatient settings for some of the most common surgeries among Medicare
13 patients—hip, knee, and, more recently, ankle replacements, also referred to as LEJR.¹⁹ CJR began
14 in 2016 and has been mandatory since 2017 for hospitals in 34 geographic areas where spending
15 had been historically high.²⁰ Over CJR’s first four years, payments across LEJR episodes in CJR’s
16 mandatory areas were 5.2 percent lower than the baseline, with payments averaging \$1,511 less per
17 episode. An independent evaluation estimated small net savings for the Medicare program in
18 earlier years but was unable to conclude definitively that Medicare realized net savings over the
19 first four years of the initiative. Over the four-year period, independent evaluators estimated that,
20 after accounting for reconciliation payments, net savings ranged from a possible \$15.3 million
21 more in Medicare spending to \$167.2 million in savings.²¹ Similar to other surgical bundles,
22 changes in post-acute care utilization drove the decrease in average episode payments, as fewer
23 patients were discharged to SNFs and rehabilitation facilities, and patients who went to SNFs spent
24 fewer days there. When compared to the control group, a larger proportion of CJR patients were
25 discharged to home health agencies, which cost significantly less than institutional post-acute
26 care.²² CJR patient care quality, as measured by unplanned readmissions, emergency department
27 use, and mortality rates, was maintained over the four-year period. Furthermore, patients in the
28 CJR and control groups reported similar functional status gains, pain levels, and overall
29 satisfaction, although some CJR patients reported that they required more caregiving help at home
30 and CJR hip replacement patients reported less improvement on three of eight functional status
31 measures.²³ In terms of unintended consequences, evaluators identified a decrease in patient
32 complexity that could indicate some level of risk selection but no evidence of increased LEJR
33 volume.²⁴ Although a *New England Journal of Medicine* study of CJR’s first two years did not find
34 adverse effects on complications, hospital readmissions, or mortality, it did not look at functional
35 status, pain, and patient satisfaction indicators. This study examined whether the CJR program
36 incentivizes hospitals to 1) treat healthier rather than sicker patients (risk selection); and/or 2)
37 reduce the use of SNF and inpatient rehabilitation. With regard to risk selection, the study noted
38 inconsistent evidence in previous studies and no changes in patient selection in the current study
39 other than some evidence that fewer disabled patients underwent procedures.²⁵ Because CJR did
40 not negatively affect complications, readmissions, or mortality, the study authors concluded that
41 hospitals may have correctly identified patients who could be appropriately discharged home with
42 home health instead of being referred to institutional post-acute settings.²⁶

43
44 A systemic review of CMS’s Acute Care Episode Demonstration (a three-year bundled payment
45 model for inpatient cardiac and orthopedic surgeries), BPCI, and CJR initiatives found no
46 associations between these Medicare models and 1) quality of care—as measured by readmissions,
47 emergency department visits, and mortality—and 2) unintended consequences, such as increased
48 utilization or risk selection.²⁷ This review further found that, in six out of 16 studies that evaluated
49 spending, bundled payments significantly decreased episode costs; importantly, these six studies
50 focused on orthopedic surgery and four of the six looked at LEJR episodes. Other clinical or
51 medical episodes were not found to be associated with episode savings.²⁸ A separate review of 16

1 Medicare bundled payment initiatives similarly found that Medicare spending decreased for LEJR
 2 episodes but not for most other bundled payment models unless provider fees were heavily
 3 discounted.²⁹ This review found limited evidence of risk avoidance across models although the
 4 evidence was mixed.³⁰ The authors highlighted the association between bundled payments and
 5 post-acute care spending, with payments and service intensity more likely to decrease under
 6 bundles that included post-acute care services in the bundle and increased post-acute care
 7 utilization in models that did not include post-acute care services in the bundle. Like other studies,
 8 no association was found between bundled payments and increased episode volume.³¹

9
 10 *Episode Programs in Maryland:* Within its Total Cost of Care All-Payer Model, Maryland has
 11 several CMMI-approved advanced payment initiatives specific to that state, including the Episode
 12 Quality Improvement Program (EQIP) launched in 2022 for specialist physicians in Medicare.³²
 13 This program provides opportunities for more non-hospital providers to participate in bundles
 14 relevant to a range of specialties, including gastroenterology, cardiology, and orthopedics, which
 15 were implemented in year one, as well as additional episodes that have been rolled out since. As of
 16 January 2023, 43 medical specialties were represented in 45 episodes available under EQIP.³³

17
 18 *Select Medicaid Episodes of Care*

19
 20 Although Medicaid programs employ a range of value-based payment programs, including
 21 episodes of care for various conditions and procedures, they have not been as high profile as some
 22 Medicare-focused models. Furthermore, while there is a wealth of published studies of Medicare
 23 bundled payment initiatives, the research literature is less robust for Medicaid models and not all
 24 states implementing episodes of care make cost and performance data publicly available.
 25 Accordingly, the Council reviewed available data from select states that were early adopters of
 26 episodes of care, including Tennessee, Ohio, and Arkansas, as well as a Medicaid and CHIP
 27 Payment and Access Commission (MACPAC) analysis of perinatal episodes implemented across
 28 three states.

29
 30 *Perinatal:* Because Medicaid covers nearly half (42 percent in 2020) of all births in the U.S.,³⁴
 31 several states have implemented episode-based payments for perinatal care. A 2021 MACPAC
 32 analysis reviewed perinatal episodes of care implemented in Arkansas, Colorado, and Tennessee.
 33 Although the Arkansas and Tennessee models were generally viewed positively in terms of
 34 reducing cost variations, Arkansas sunset its model, which had been mandatory, in 2021, due in
 35 part to administrative burdens on providers and diminishing returns as cost variations narrowed
 36 over time. The Tennessee and Arkansas models reduced costs per episode but produced mixed
 37 results on quality measures.³⁵ Because the Colorado model began later, in 2020, with only a few
 38 participants at the start, data on its impact on episode costs was not available at the time this report
 39 was written. Although high-risk pregnancies were excluded from episode-based payments in
 40 Arkansas and Tennessee, the Colorado model, which is voluntary, includes some high-risk patients,
 41 including those with substance use disorders. Importantly, while certain quality measures are
 42 tracked by states, there is no published evidence on the impact of perinatal episodes of care on
 43 maternal health or birth outcomes. Moreover, incentives are generally not tied to key metrics
 44 related to reductions in maternal morbidity and mortality, or impact on health disparities.³⁶

45
 46 *Tennessee:* Aside from its perinatal model, Tennessee's Medicaid program, known as TennCare,
 47 has administered close to 50 episodes of care since 2013. TennCare reported that, in 2018, 22 of
 48 the 27 episodes of care tied to incentive payments saved the state an estimated \$38.3 million. The
 49 five that did not show savings were for acute percutaneous coronary intervention, non-acute
 50 percutaneous coronary intervention, gastrointestinal hemorrhage, bariatric surgery, and human
 51 immunodeficiency virus episodes, which the state described as low volume, making savings more

1 difficult to achieve. Episodes producing the most savings in 2018 included the perinatal model
2 (\$13.5 million in savings), respiratory infection episode (\$6.8 million), and the asthma acute
3 exacerbation episode (\$4.2 million).³⁷ Quality of care, as measured by certain performance metrics,
4 was mostly maintained or improved except for low-volume episodes in which quality metric
5 performance declined.³⁸ Because TennCare waived all episodes of care incentives through 2021
6 due to the Covid-19 pandemic, more recent evaluation data was not available for review.

7
8 *Ohio:* Ohio's Department of Medicaid, which has administered 43 episodes of care since 2015,
9 similarly suspended its episodes of care incentives between 2020 and 2022 due to Covid-19's
10 impact on the state's providers. Data from 2019 showed that Ohio's episodes of care covered more
11 than 1.5 million patients that year, or 51 percent of the state's Medicaid enrollees.³⁹ From 2013 to
12 2019, Ohio participated in CMMI's State Innovation Model (SIM) initiative, which helped
13 facilitate the design and launch of the state's episodes of care as well as its comprehensive primary
14 care program. Results from the first two years of Ohio's episodes of care program were generally
15 positive and showed reductions in average episode costs overall with no adverse effects on care
16 quality. For the nine episodes linked to incentives in 2017 (asthma exacerbation, chronic
17 obstructive pulmonary disease exacerbation, perinatal, cholecystectomy, upper respiratory
18 infection, gastrointestinal bleed, urinary tract infection, colonoscopy, and
19 esophagogastroduodenoscopy), average non-risk-adjusted spending decreased by 0.9 percent
20 annually, saving an estimated \$31.8-\$92.2 million.⁴⁰ That same year, providers received \$4 million
21 in positive incentives and were accountable for \$4 million in negative incentives.⁴¹ In its final SIM
22 report issued in 2019, the Ohio Department of Medicaid identified several factors that were key to
23 the successful design and implementation of its episodes of care, including ongoing provider
24 engagement, addressing provider challenges, streamlining reporting burdens, engaging private
25 insurers in the state, facilitating consistency across public and private health plans, and aligning
26 episodes of care with population health priorities. The episodes of care initiative further benefited
27 from strong leadership in the state, a dedicated innovation team, and alignment with federal
28 models. In 2019, Ohio's episodes of care model was approved as an advanced APM.⁴²

29
30 *Arkansas:* Support from the federal SIM initiative also helped Arkansas develop new payment
31 models and refine and expand episodes of care that were first implemented by the state's Medicaid
32 program in 2011.⁴³ By the end of the SIM initiative in 2016, Arkansas had produced 14 episodes of
33 care that were mandatory for Medicaid providers and voluntary for the state's two private payers.⁴⁴
34 Challenges early on ranged from a degree of provider hesitation and pushback to evidence that
35 coding had been used by some providers to avoid triggering certain episodes. The state reported
36 that average costs for attention-deficit/hyperactivity disorder and joint replacement episodes had
37 decreased significantly while the costs of other episodes, and episodes of care overall, remained
38 relatively constant.⁴⁵ One of the most prevalent models in Arkansas, for upper respiratory tract
39 infections (URIs), showed significant quality improvements after two years, including greater
40 reductions in antibiotic use and improvements in appropriate care for children, relative to a
41 comparison group. However, emergency department visits increased during that time span and
42 some physicians reported in focus groups using alternate coding to avoid triggering an episode.⁴⁶
43 Between 2011 and 2014, URI-related professional and outpatient spending increased while
44 spending on prescription drugs (antibiotics and others) did not change. Over the same time period,
45 the state's perinatal episode was found to decrease emergency department visits but increase
46 inpatient hospital utilization and, importantly, perinatal expenditures declined, and improvements
47 were made across most quality metrics.⁴⁷ A 2020 analysis of perinatal and URI episodes of care in
48 Arkansas concluded that: linking incentives to performance metrics may help improve quality of
49 care; episodes of care may successfully discourage the overuse of services; and unintended
50 consequences are possible, including episode avoidance through coding, a shift of services to
51 outside of the episode, and increased emergency department use.⁴⁸

1 A study of Arkansas' perinatal episode that included privately insured patients found that spending
2 decreased 3.8 percent when compared to nearby states, with savings due primarily to decreased
3 inpatient care prices.⁴⁹ Notably, although some states implementing episodes of care involve
4 commercial payers in their program design and implementation, fewer published analyses have
5 assessed the impact of bundled/episode-based payments among commercially insured patients or
6 across multiple payers. Accordingly, much less is known about the impact of commercial models
7 on spending and care quality. A 2022 meta-analysis looking at various value-based care models in
8 the commercial sector, including nine studies of bundled/episode-based payments, found mixed
9 results on spending and quality but cited significant savings incurred under UnitedHealthcare's
10 cancer bundle.⁵⁰ A recent study of the use of bundled payments for certain surgical procedures
11 among self-insured employers found considerable reductions in episode prices.⁵¹ As more research
12 becomes available and models are refined, increased alignment of bundled/episode-based payments
13 across Medicare, Medicaid, and private insurers may help expand successful models and align
14 quality reporting.

15

16 **AMA POLICY**

17

18 The AMA has an abundance of policies addressing persistent concerns with value-based payment
19 and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849). Under Policy D-385.963,
20 the AMA works with CMS and other payers on evolving payment reforms and ensuring sufficient
21 payments so that patients and families have access to care coordination supports that they need to
22 achieve optimal outcomes. Policy H-385.913 supports goals that should be pursued as part of an
23 APM, including that models be designed by physicians or with significant input from physicians,
24 provide flexibility to physicians to deliver the care their patients need, provide adequate and
25 predictable resources to support the services physician practices need to deliver to patients (and
26 include mechanisms for updating payment amounts), limit physician accountability to aspects of
27 spending and quality that they can reasonably influence, and avoid placing physician practices at
28 substantial financial risk. Policy H-385.913 also directs the AMA to continue to educate physicians
29 about APMs and provide educational resources and support. Policy H-385.908 urges CMS to limit
30 financial risk requirements to costs that physicians participating in an APM have the ability to
31 influence or control and directs the AMA to work with stakeholders to improve risk adjustment
32 systems, attribution methods, and performance target setting. Policy H-390.849 advocates for
33 physician payment reforms that: promote improved patient access to high-quality, cost-effective
34 care; are designed with input from physicians; ensure that physicians have an appropriate level of
35 authority over bonus or shared-savings distributions; and include ongoing evaluations to ensure the
36 reforms are improving patient care and increasing value.

37

38 Policy H-390.849 also opposes bundling of payments in ways that limit care or otherwise interfere
39 with a patient's ability to provide high quality care, while Policy H-385.913 supports the provision
40 of flexibility under APMs so that physicians can deliver the care patients need. Policy H-385.908
41 focuses on reducing barriers to APMs, including limiting financial risk requirements to costs that
42 physicians can control and working with stakeholders to improve attribution methods, risk
43 adjustment systems, and performance target setting. Under Policy H-70.949, the AMA will take
44 steps to ensure that public and private payers do not bundle services inappropriately; Policy
45 D-390.961 directs the AMA to work with appropriate officials to ensure that bundled payments, if
46 implemented, do not lead to hospital-controlled payments to physicians. Additional policy on
47 physician-focused payment reforms includes Policies D-390.953, H-390.844, H-450.931, and
48 H-450.961. Policy H-450.931 directs the AMA to help physician practices address concerns about
49 APMs and harmonize key components of APMs across multiple payers, including performance
50 measures.

1 Improving risk adjustment across payment models is addressed by Policies H-385.907 and
 2 H-285.957, and D-385.952, which also support linking quality measures and payments to outcomes
 3 specific to high-risk populations and reductions in health care disparities. Policy
 4 H-385.907 supports: 1) risk stratification systems that use fair and accurate payments based on
 5 patient characteristics, including socioeconomic factors; 2) risk adjustment systems that use fair
 6 and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and
 7 accurate payments for external price changes beyond the physician’s control; 3) risk adjustment
 8 systems that use risk corridors using fair and accurate payment if spending on all patients exceeds a
 9 pre-defined percentage above the payments; 4) accountability measures that exclude from risk
 10 adjustment methodologies any services that the physician does not deliver, order, or otherwise have
 11 the ability to influence; and 5) risk adjustment mechanisms that allow for flexibility to account for
 12 changes in science and practice. Policy H-165.837 advocates for protecting the patient-physician
 13 relationship in the context of bundled payments and affirms the obligation of physicians to
 14 prioritize patient care above financial interests.

15

16 AMA ADVOCACY

17

18 Many of the concerns about bundled/episode-based payment models have previously been
 19 addressed by AMA policy and advocacy on [payment reform](#) and [APMs](#). Key characteristics of
 20 value-based care, including that new models and incentives must be tailored to the distinct
 21 characteristics of different specialties and practice settings, were also incorporated into the
 22 [Medicare payment system principles](#) crafted by the AMA in collaboration with 120 other physician
 23 and health care organizations. The AMA has worked diligently over the years to improve MACRA
 24 and advance the transition to value-based care and now leads the charge to reform Medicare’s
 25 payment system to increase physician payment stability, reduce burnout, and improve the financial
 26 viability of physician practices. Although the Consolidated Appropriations Act of 2023 extended
 27 the five percent advanced APM incentive payment for 12 months, the AMA is advocating that it be
 28 extended for additional years.

29

30 The AMA continues to encourage and enable physician participation in physician-focused APMs,
 31 including bundled/episode-based payments. The AMA believes that well-designed, patient-
 32 centered APMs can provide significant opportunities to improve the quality and outcomes of
 33 patients’ care in ways that also lower growth in health care spending. However, the AMA
 34 maintains that physicians must be involved in the design of APMs to ensure that models
 35 successfully remove certain barriers and do not require physicians to be accountable for spending
 36 or outcomes they cannot control. The AMA continues to carefully examine APMs that are
 37 proposed by CMS and provide feedback to the agency regarding needed modifications, including
 38 when APMs impose unreasonable requirements on physicians or require them to take on excessive
 39 financial risk. Because the AMA believes that APMs are significantly improved when physicians
 40 are directly and actively involved in their design, the AMA continually advocates for consideration
 41 of physician input on models and approval of APMs that have been designed by physicians.

42

43 The AMA works closely with national medical specialty societies to review proposed APMs,
 44 recommend model improvements, and comment on regulations governing APMs. A more recent
 45 example is the AMA’s advocacy focused on Medicare’s proposed Radiation Oncology (RO)
 46 Model, a bundled payment for cancer patients receiving radiotherapy, which the AMA urged be
 47 delayed so that CMS could work with radiation oncology specialty societies to redesign some of
 48 the model’s key features.⁵² The RO Model that CMS had previously developed could have had
 49 serious unintended consequences for patients because practices would have been mandated to
 50 participate and take steep payment cuts. Accordingly, the AMA expressed general support for the
 51 creation of a bundled payment model for radiation oncology but advocated that several changes be

1 made to CMS’s proposal, namely that payments be stratified based on patients’ clinical
 2 characteristics, adjusted to account for the higher costs of delivering services in rural areas, and
 3 adjusted annually to reflect changes in evidence, technology, and inflation.⁵³ The AMA has further
 4 urged CMS to conduct a limited scale test of the RO Model on a voluntary basis rather than
 5 mandating participation in an untested model.

6
 7 In 2015, the AMA recommended numerous changes to the proposed CJR model and urged CMS to
 8 make participation voluntary and available to physicians in all localities. Among other
 9 modifications to its original design, the AMA recommended that payments be risk-adjusted based
 10 on patients’ functional status and other characteristics that affect the types of post-acute care they
 11 need so that physicians could assign patients to one of several acuity/risk levels and receive higher
 12 payments for higher-risk patients.⁵⁴ Additional advocacy on CJR and other episode-based payment
 13 models has repeatedly urged CMS to incorporate input from relevant national medical specialty
 14 societies in model design and revisions; listen to affected specialty societies that have experience
 15 with the different risks facing patients treated under the models; allow voluntary participation;
 16 begin episodes at the time of diagnoses of a condition instead of at hospital admission; and ensure
 17 that payment is adequate and predictable while limiting physicians’ accountability to costs within
 18 their control. More recent AMA advocacy with CMS on episode-based payment models in
 19 Medicare included support for bundled payments for office-based management of patients with
 20 substance use disorders and bundled payments for chronic pain management.

21
 22 To be successful, the AMA believes a physician-focused APM needs three key components:

- 23
 24 1. Flexibility for physicians to deliver the most appropriate services to meet patients’ needs;
- 25 2. Adequate payments to support the costs physicians incur in delivering high-quality care;
- 26 and
- 27 3. Accountability by physicians for delivering high-quality services and avoiding unnecessary
- 28 services, but without penalties for things that physicians cannot control.
- 29

30 The AMA has held educational seminars about APMs for physicians and organized several
 31 workshops in which physicians have shared their experiences in designing and implementing
 32 APMs. Physicians who want to learn more about episodes of care and other APMs are encouraged
 33 to read the following AMA resources: [Evaluating Medicaid Value-Based Care Models](#), [Evaluating](#)
 34 [Bundled or Episode-Based Contracts](#), and [Medicare Alternative Payment Models](#).

35
 36 DISCUSSION

37
 38 Although the concerns highlighted in referred Resolution 111-A-22 focused primarily on Medicaid
 39 episodes of care, the Council reviewed available research on both Medicaid and Medicare bundled
 40 payment models. Evidence in the literature suggests that certain Medicare bundles may contain
 41 overall costs more effectively than fee-for-service payment but, after accounting for provider
 42 bonuses, aside from joint replacement models, most have not produced net Medicare savings.
 43 Additionally, although studies have been mixed and vary across initiatives, most bundled payment
 44 models have neither significantly improved nor worsened quality of care.⁵⁵ The Council found that
 45 LEJR bundles, and some perinatal episodes of care, have produced the most—but still modest—
 46 savings. LEJR episode savings have been driven by reductions in institutional post-acute care (e.g.,
 47 SNFs and inpatient rehabilitation facilities) spending while hospital pricing contributed to
 48 reductions in perinatal episode spending. The Council was unable to locate published studies
 49 analyzing the impact of bundled/episode-based payment models on physician payment; however,
 50 we reviewed several studies looking at other possible unintended consequences of these models.
 51 For example, studies have found some evidence of risk selection across certain Medicare bundles,

1 although the evidence has been mixed, and no evidence of increased episode volume, which had
 2 been an early concern among some stakeholders. A study of episodes of care in Arkansas revealed
 3 other possible unintended consequences, including episode avoidance through coding, a shift of
 4 some services outside of the bundles, and increased emergency department use.

5
 6 Because the evidence is clear that the savings accrued under LEJR episodes has been due to
 7 decreased spending on SNFs and inpatient rehabilitation facilities, some physicians have
 8 questioned whether patient access to medically necessary care, including SNF services, could
 9 potentially be limited. The Council believes that performance metrics measuring key patient-
 10 centered outcomes, including functional improvements after orthopedic and other procedures, are
 11 important and necessary checks on the risk that some models may underserve patients. Because the
 12 AMA already has extensive policy on APMs, we recommend amending Policies H-390.849[2, 3]
 13 and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific
 14 to bundled/episode-based payments.

15
 16 Although evidence across models is limited, high-risk patients have not been found to be adversely
 17 impacted under the BPCI initiative; more research is needed on how historically marginalized
 18 patients fare, in terms of outcomes, under a broader range of episodes. One study we reviewed
 19 found that hospitals serving historically marginalized individuals performed well, and received
 20 large bonuses, under BPCI Advanced; however, more studies are needed to ensure that
 21 implementation of episode-based models is meaningfully supporting equity goals. The Council
 22 previously addressed concerns about the impact of APMs on high-risk populations and points to
 23 Policy D-385.952, which we recommend amending. To address other concerns and obstacles under
 24 bundled/episode-based payment models, the Council recommends reaffirmation of Policy
 25 H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which
 26 outlines goals to be pursued as part of physician-focused APMs—including that models be
 27 designed by physicians or with significant input from physicians, provide flexibility to physicians
 28 to deliver the care patients need, provide adequate and predictable resources, and avoid placing
 29 physician practices at substantial financial risk—and directs the AMA to continue to work with
 30 national medical specialty societies and state medical associations to educate physicians on APMs.

31
 32 As previously noted, one of the frustrations with episode-based payment models concerns the
 33 definition of related or unrelated services. For example, since some LEJR models include most
 34 Medicare Part A and Part B services, payment for seemingly unrelated procedures (e.g., eye, skin,
 35 or sinus surgeries) completed within 90 days of a joint replacement may be paid for out of the
 36 bundled payment. AMA policy addresses this concern by advocating that physician accountability
 37 be limited to aspects of spending and quality that they can reasonably influence or control. Notably,
 38 the services covered under joint replacement models can vary significantly across payers so that
 39 services included in a state Medicaid model may differ from CJR’s list of covered services.

40
 41 Although the Council discussed the need for bundled payment models to clearly define the services
 42 included and allow mechanisms for shifting unrelated services outside of the bundle, we believe
 43 this is best addressed at the design stage, with meaningful physician involvement, as highlighted by
 44 Policy H-385.913. The Council encourages physicians interested in participating in bundled
 45 payment models to determine ahead of time which services and Current Procedural Terminology
 46 codes are included and not included in an episode, and to review the AMA’s [Evaluating Bundled or
 47 Episode-Based Contracts](#) for more information. Finally, the Council believes well-designed,
 48 patient-centered bundled payment models can improve care quality and patient outcomes in ways
 49 that also lower growth in health care spending. Designing these models to work effectively for
 50 patients, physicians, and payers remains challenging, and ongoing refinements to models may be
 51 needed to ensure optimal patient outcomes as these initiatives continue to expand.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 111-A-22, and that the remainder of the report be filed:

5
6 1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition
7 and deletion to read as follows:

8
9 2. Our AMA opposes bundling of payments in ways that limit medically necessary care,
10 including institutional post-acute care, or otherwise interfere with a physician's ability to
11 provide high quality care to patients.

12 3. Our AMA supports payment methodologies that redistribute Medicare payments among
13 providers based on outcomes (including functional improvements, if appropriate), quality
14 and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate,~~
15 ~~and based on current data~~ reliable, and consistent with national medical specialty society-
16 developed clinical guidelines/standards. (Modify HOD Policy)

17
18 2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:

19
20 Our AMA: (1) supports alternative payment models (APMs) that link quality measures and
21 payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in
22 health care disparities, and functional improvements, if appropriate; (2) will continue to
23 encourage the development and implementation of physician-focused APMs that provide
24 services to improve the health of vulnerable and high-risk populations and safeguard
25 patient access to medically necessary care, including institutional post-acute care. (Modify
26 HOD Policy)

27
28 3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that
29 use fair and accurate payments based on patient characteristics, including socioeconomic
30 factors; risk adjustment systems that use fair and accurate outlier payments if spending on
31 a patient exceeds a pre-defined threshold, and fair and accurate payments for external price
32 changes beyond the physician's control; and accountability measures that exclude from
33 risk adjustment methodologies any services that the physician does not deliver, order, or
34 otherwise have the ability to influence. (Reaffirm HOD Policy)

35
36 4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused
37 APMs—including that models be designed by physicians or with significant input from
38 physicians, provide flexibility to physicians to deliver the care patients need, limit
39 physician accountability to aspects of spending and quality that they can reasonably
40 influence, and avoid placing physician practices at substantial financial risk—and directs
41 the AMA to continue working with national medical specialty societies and state medical
42 associations to educate physicians on APMs. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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APPENDIX

Policies Recommended for Reaffirmation and Amendment

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22)

Physician-Focused Alternative Payment Models H-385.913

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.

4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:

- A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
- B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
- C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
- D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
- E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.

5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. ([CMS Rep. 09, A-16](#); [Reaffirmed: CMS Rep. 10, A-17](#); [Reaffirmed: CMS Rep. 10, A-19](#); Reaffirmed: BOT Rep. 13, I-20; [Reaffirmed: CMS Rep. 2, A-22](#))

Alternative Payment Models and Vulnerable Populations D-385.952

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (CMS Rep. 10, A-19)

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22)

REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which asked the American Medical Association to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

“Multiple services” can refer to two evaluation and management (E/M) services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter, all of which can be appropriately reported with the existing Current Procedural Terminology (CPT®) nomenclature. CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. While CPT includes several modifiers, the one most commonly reported for multiple services is modifier 25, which is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service. Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient’s condition to be appropriately reported and, therefore, appropriately paid.

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 07-A-23

Subject: Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

1 At the November 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22,
2 which was sponsored by the Private Practice Physicians Section. Resolution 824-I-22 asked the
3 American Medical Association (AMA) to recognize that there is greater value to the patient,
4 improved access to care, greater patient satisfaction, and improved overall patient care by
5 advocating for appropriate payment for multiple services (two or more) to be performed during a
6 single patient encounter. Testimony at the November 2022 Interim Meeting regarding the
7 resolution was mixed, with some speakers offering vignettes to support the need for Resolution
8 824-I-22 and others questioning the need for it given recent revisions to Current Procedural
9 Terminology (CPT®) Evaluation and Management (E/M) codes that allow physicians to report
10 encounters involving multiple services during a single patient encounter. This report focuses on the
11 need for education of physicians and payers on appropriate reporting of multiple services using
12 CPT nomenclature, provides a snapshot of strategies insurers use to deny claims, highlights AMA
13 advocacy efforts and essential policy, and presents new policy recommendations.

14
15 **BACKGROUND**

16
17 As outlined in Resolution 824-I-22, “multiple services” can refer to two E/M services, a procedure
18 plus an E/M service, or two or more procedures provided by the same physician during a single
19 patient encounter. CPT is the most widely accepted US medical nomenclature for reporting
20 singular or multiple medical services and procedures under public and private health insurance
21 programs. In addition to being the code set adopted under the Health Insurance Portability &
22 Accountability Act of 1996 (HIPAA) for outpatient services and procedures¹, CPT codes create a
23 uniform language for reporting medical services and procedures to allow accurate and efficient
24 claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which
25 are appended to codes to indicate that a service or procedure has been altered by a specific
26 circumstance but not changed in its definition. The use of modifiers provides supplementary
27 information for payer policy requirements.

28
29 While CPT provides a valid way to report multiple services, the resulting claims can result in high
30 rates of denials. Payers may flag all multiple services claims for prepayment claim validation prior
31 to payment or require submission of documentation with the claim, both of which create
32 unjustifiable administrative burden for physicians, an incumbrance exacerbated in rural
33 communities and other areas with limited health care resources. Addressing rural health inequities
34 is a cornerstone of the Centers for Medicare & Medicaid Services’ (CMS) effort to improve health

1 equity,² a goal that can be achieved by consistent application of CPT across all payers given its
2 ability to promote health equity.³

3
4 Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of
5 providing, documenting, reporting, and paying for multiple services. This can be confounded
6 further by use of electronic health records (EHR), which can make it difficult to ensure accurate
7 data if codes and medical terms are not used consistently. Therefore, it becomes imperative that
8 both physicians and payers are well educated on the appropriate way to report multiple services as
9 well as the circumstances that justify such reporting. It is also important that the CPT guidelines
10 used to recognize the validity of claims for multiple services are consistently applied, which may
11 be facilitated by the development of EHR tools.

12 13 MODIFIER 25

14
15 CPT modifier 25 is appended to an E/M service code on a claim to indicate the code is a
16 significant, separately identifiable E/M service by the same physician or other qualified health care
17 professional on the same day of the procedure or other service.⁴ Its use allows two E/M services or
18 a procedure plus an E/M service that are distinctly different but required for the patient's condition
19 to be appropriately reported and, therefore, appropriately paid. The CPT Professional Edition also
20 states that a significant, separately identifiable E/M service is defined or substantiated by
21 documentation that satisfies the relevant criteria for the respective E/M service to be reported.⁵
22 While CPT does not outline required documentation for modifier 25, its use indicates that
23 documentation is available in the patient's record to support the reported E/M service as distinct
24 and separately identifiable. Further, the E/M service may be prompted by the symptom or condition
25 for which the procedure and/or service was provided. As such, different diagnoses are not required
26 for reporting of the E/M services on the same date.

27
28 There are two scenarios where modifier 25 is typically used:

- 29
30 1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other
31 Outpatient E/M service:

32
33 This is a common scenario in pre- or non-verbal patients. For example, a 2-year-old is seen
34 for their well child visit and the physician finds otitis media during the physical
35 examination. When a significant problem is encountered while performing a Preventive
36 Medicine E/M service, requiring additional work to perform the key components of the E/M
37 service, the appropriate Office or Other Outpatient E/M code also should be reported for
38 that service with modifier 25 appended. Modifier 25 allows separate payment for these
39 visits without requiring documentation with the claim form.

- 40
41 2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient
42 E/M service:

43
44 CPT codes for minor surgical procedures include preoperative evaluation services (i.e.,
45 assessing the site or problem, explaining the procedure, risks, and benefits, and obtaining
46 consent). Therefore, the E/M service has to involve work "above and beyond" the
47 preoperative evaluation services. For example, when a patient presents with a head
48 laceration, and the physician also performs a neurological examination before repairing the
49 laceration, the neurological exam would merit a separate E/M service reported with
50 modifier 25.

1 The CPT Professional 2023 codebook definition of a significant, separately identifiable service
2 relies on satisfying the relevant criteria for determining the correct level of E/M service to be
3 reported. The following questions can be used to determine whether an E/M service justifies use of
4 modifier 25 according to CPT guidelines:

- 5 • Did the physician perform and document the level of medical decision making or total time
6 necessary to report a problem-oriented Office or Other Outpatient E/M service for the
7 complaint or problem?
- 8 • Could the work to address the complaint or problem stand alone as a billable service?
- 9 • Did the physician perform extra work that went above and beyond the typical pre- or
10 postoperative work associated with the procedure code?

11
12 If all answers are “yes,” then use of modifier 25 is consistent with CPT guidelines.

13
14 CMS requires that modifier 25 be used:

- 15 • Only on claims for E/M services and
- 16 • Only when the E/M service is provided by the same physician on the same day as another
17 procedure or service.

18
19 While these two requirements are consistent with CPT guidelines, Medicare policy is more
20 restrictive in that it will not pay for more than one E/M service provided by the same physician on
21 the same day unless the visits are for unrelated problems and could not be provided during the
22 same patient encounter. For example, Medicare will not pay separately when a patient is seen for
23 their annual preventive checkup and the physician finds otitis media during the physical
24 examination – even with the use of modifier 25. However, Medicare will pay for a patient who
25 presents for blood pressure medication evaluation and then returns five hours later that same day
26 for evaluation of leg pain following an accident – if modifier 25 is used.

27
28 Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is
29 reported with a global procedure. Global procedures include visits and other physician services
30 provided within 24 hours prior to the service, provision of the service, and visits and other
31 physician services for a specified number of days after the service is provided.

32
33 CMS defines global surgical packages based on the number of postoperative days it assigns to the
34 service:

- 35 • XXX: Global period does not apply
- 36 • 0-day global period: Includes procedure and visit on day of procedure
- 37 • 10-day global period: Includes procedure, visit on day of procedure, and visits 10 days
38 immediately following the day of the procedure
- 39 • 90-day global period: Includes procedure, visit on day of procedure, and visits 90 days
40 immediately following the day of the procedure

41
42 Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day
43 and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor
44 surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service
45 work inherent in the procedure, the physician cannot report an E/M service for this work in most
46 circumstances when the minor surgical procedure or XXX-global is the primary procedure.
47 Furthermore, Medicare policy prevents the reporting of a separate E/M service for the work
48 associated with the decision to perform a minor surgical procedure.

49
50 All E/M services provided on the same day as a procedure are considered part of the procedure and
51 Medicare only makes separate payment if an exception applies. Modifier 25 is used to provide

1 justification for a visit that is “generally not payable,” as Medicare payment is made only if the
2 physician indicates that the service is for a significant, separately identifiable E/M service that is
3 above and beyond the usual pre-service and post-service work required on the day of the
4 procedure. Modifier 25 may be used in the rare circumstance of an E/M service the day before a
5 procedure which represents a significant, separately identifiable service; it typically is linked to a
6 different diagnosis than the underlying reason for the procedure (e.g., evaluation of a cough that
7 might contraindicate surgery).⁶ Medicare requires that the physician appropriately and sufficiently
8 document both the medically necessary E/M service and the procedure in the patient’s medical
9 record to support the claim for these services, even though the documentation is not required to
10 submit with the claim.⁷

11
12 CMS has focused on the potential misuse of modifier 25 since 2005, when the Office of the
13 Inspector General (OIG) published an analysis indicating that 35 percent of Medicare claims
14 involving modifier 25 did not meet CMS requirements.⁸ Since that time, both Medicare and private
15 payers have increased their scrutiny of claims submitted with modifier 25, which has led to
16 substantial recoupment of physician payments. The OIG continues to maintain modifier 25 as a
17 target of its work plan and is expected to release a report of modifier 25 use in dermatology in late
18 2023.

19 20 OTHER CPT MODIFIERS USED FOR REPORTING MULTIPLE SERVICES

21
22 In addition to modifier 25, CPT includes other modifiers to allow the reporting of multiple
23 services:⁹

- 24
25 • Modifier 24: Unrelated E/M service provided by the same physician or other qualified
26 health care professional during a postoperative period
- 27 • Modifier 51: Multiple procedures, non-E/M procedures provided by the same individual at
28 the same session
- 29 • Modifier 57: Decision for surgery, an E/M service that resulted in the initial decision to
30 perform surgery
- 31 • Modifier 58: Staged or related procedure or service by the same physician or other
32 qualified health care professional during the postoperative period
- 33 • Modifier 59: Distinct procedural service, an independent non-E/M service performed on
34 the same day Modifier 59 is used to identify non-E/M procedures/services that are not
35 normally reported together but are appropriate under the circumstances. Documentation
36 must support a different session, different procedure or surgery, different site or organ
37 system, separate incision/excision, separate lesion, or separate injury (or area of injury in
38 extensive injuries) not ordinarily encountered or performed on the same day by the same
39 individual. Modifier 59 should only be used if no more descriptive modifier is available,
40 and the use of modifier 59 best explains the circumstances.
- 41 • Modifier 78: Unplanned return to the operating/procedure room by the same physician or
42 other qualified health care professional following initial procedure for a related procedure
43 during the postoperative period
- 44 • Modifier 79: Unrelated procedure or service performed by the same physician or other
45 qualified health care professional during the postoperative period

1 CPT CODES AND GUIDELINES THAT FACILITATE THE REPORTING OF MULTIPLE
2 SERVICES

3
4 Prolonged Service

5
6 There are Prolonged Service CPT codes that permit the reporting of time spent beyond the highest
7 time in the range of total time of the primary E/M service. Prolonged Service CPT codes are
8 reported in 15 minute increments, allowing physicians to be paid for providing extended services
9 during a single patient encounter (even if the time on that date is not continuous) that contribute
10 toward the total time of the visit.

11
12 The AMA is currently advocating to align CMS's interpretation of the Prolonged Service codes
13 with the CPT definition as described above. Medicare, however, requires that the physician surpass
14 the maximum time of the highest E/M level by 15 minutes. Until such time that CPT and CMS
15 interpretations are reconciled, Medicare requires reporting of Healthcare Common Procedure
16 Coding System Level II codes in lieu of CPT codes for reporting prolonged services.

17
18 Care Management

19
20 Care Management CPT codes are E/M codes reported monthly for physician oversight and
21 management of clinical staff in the development and implementation of the care plan and care
22 coordination in patients with one or more complex chronic conditions. Care Management codes
23 can be reported in addition to other E/M codes (e.g., Office or Other Outpatient Services). Time
24 that is spent providing services within the scope of the Care Management service on the same day
25 as an E/M visit can be counted towards Care Management codes, as long as the time is not counted
26 towards the other reported E/M code(s).

27
28 Total Visit Time Versus Medical Decision Making

29
30 E/M codes are selected based on either the total time spent or medical decision making (MDM)
31 required. The decision of which component to use in selecting the appropriate E/M code is
32 determined by the reporting physician or qualified health care professional based on the available
33 criteria.

34
35 MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a
36 management option. There are three elements to MDM:

- 37 • Number and complexity of problems addressed at the encounter
- 38 • Amount and/or complexity of data to be reviewed and analyzed
- 39 • Risk of complications and/or morbidity or mortality of patient management

40
41 Time is based on the total time spent on the date of the encounter. It includes both face-to-face time
42 with the patient and non-face-to-face time spent on things such as care coordination, consulting
43 with other health care professionals, and ordering medications, tests, and procedures.

44
45 Caring for a patient with multiple issues is likely to increase the total time of the encounter, which
46 may allow the physician to report a single, higher level E/M code rather than two lower level E/M
47 codes appended with modifier 25.

1 RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

2
 3 CMS considers recommendations from the AMA/Specialty Society Relative Value Scale Update
 4 Committee (RUC) process to determine relative value units (RVUs) for the RBRVS. The RBRVS
 5 is based on the principle that payments for physician services should vary with the resource costs
 6 for providing those services and is intended to improve and stabilize the payment system while
 7 providing physicians an avenue to continuously improve it. Determining RVUs through the RUC
 8 ensures that potential overlap is eliminated from the physician work, practice expense, and
 9 professional liability insurance (PLI) for services that are frequently provided together. The
 10 physician work component accounts for an average of 51 percent of the total RVU for each service
 11 while practice expense accounts for 45 percent. PLI accounts for the remaining four percent. The
 12 factors used to determine physician work include the time it takes to perform the service, the
 13 technical skill and physical effort, the required mental effort and judgment, and stress due to the
 14 potential risk to the patient. The practice expense components include clinical staff time, medical
 15 supplies, and medical equipment.

16
 17 The process of valuing CPT codes on the RBRVS contributes to determining whether use of
 18 modifier 25 is warranted. Global procedure CPT codes are valued to include pre-service (e.g.,
 19 evaluation time, patient positioning, scrub/dress/wait time), intra-service (e.g., performing the
 20 procedure, also known as “skin-to-skin” time), and post-service (e.g., patient stabilization,
 21 communicating with the patient and other professionals) work.

22
 23 For example, Medicare payment for CPT code 64635 (*Destruction by neurolytic agent,*
 24 *paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral,*
 25 *single facet joint*), includes 28 minutes pre-service time. Reporting a problem-oriented Office or
 26 Other Outpatient E/M code in addition to CPT code 64635 when evaluation is limited to assessing
 27 the specific problem is essentially double billing for the pre-service evaluation. Therefore, use of
 28 modifier 25 would not be appropriate in this situation.

29
 30 However, when a patient presents for their annual skin examination and a suspicious lesion is
 31 discovered, it is appropriate for the physician to proceed with a diagnostic or therapeutic procedure
 32 at the same visit after obtaining the patient’s medical history, completing a review of systems, and
 33 conducting a clinical examination. This situation would warrant the use of modifier 25. The ability
 34 to assess and intervene during the same visit is optimal for patients who subsequently may require
 35 fewer follow-up visits and experience more immediate relief from their symptoms.

36
 37 MULTIPLE PROCEDURE PAYMENT REDUCTIONS

38
 39 In addition to two E/M services or a procedure plus an E/M service, “multiple services” can refer to
 40 two or more procedures provided by the same physician during a single patient encounter. Payers
 41 may utilize the CMS Multiple Procedure Payment Reduction (MPPR) policy to adjudicate claims
 42 involving more than one procedure.

43
 44 Under the MPPR, Medicare makes full payment for the professional component (PC) and technical
 45 component (TC) of the highest priced procedure. Payment is made at 95 percent for subsequent PC
 46 services furnished by the same physician to the same patient in the same session on the same day.
 47 Payment is made at 50 percent for subsequent TC services furnished by the same physician to the
 48 same patient in the same session on the same day.¹⁰

49
 50 The rationale behind CMS’ MPPR policy is similar to that of its global surgical package definitions
 51 in that “most medical and surgical procedures include pre-procedure, intra-procedure, and post-

1 procedure work. When multiple procedures are performed at the same patient encounter, there is
2 often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical
3 procedures account for the overlap of the pre-procedure and post-procedure work.”¹¹

4 5 CLAIMS ADJUDICATION AND COMPLIANCE

6
7 Policies on payment for multiple services during a single patient encounter are typically
8 communicated via claims adjudication with the use of coding edits. Most private payers utilize
9 customizable, propriety claims edit systems, while Medicare and Medicaid use the coordinated
10 National Correct Coding Initiative (NCCI).

11
12 NCCI reinforces Medicare policies, and since it is common for private payers to adopt NCCI as
13 part of their customizable claims editing systems, allowing physicians the opportunity to comment
14 on NCCI takes on increased importance. Through a process coordinated by CMS and the AMA,
15 national medical specialty societies are able to review and comment on proposed NCCI updates on
16 a quarterly basis. In recent years, however, the NCCI review process has become less transparent
17 and the AMA has continued to advocate toward a return to the “solid, transparent, collaborative
18 track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the
19 past.” ([June 2021 letter](#), [November 2021 letter](#))

20
21 Edits on code pairs may be overridden by appending the appropriate modifier on one of the codes.
22 For example, NCCI includes an edit on the codes for vision screening (CPT code 99173) and a
23 level 3 established patient Office or Other Outpatient visit (CPT code 99213) – but allows override
24 of the edit with use of the appropriate modifier (i.e., modifier 25 appended to 99213). Payers’
25 increased use of claims edits has resulted in a commensurate increase in physicians’ use of
26 modifiers in an effort to override restrictive payment policies. However, that strategy may backfire
27 as some payers’ code auditing processes will flag all claims billed with modifier 25 for prepayment
28 claim validation prior to payment. Once a claim is validated, it is either released for payment or
29 denied for incorrect use of the modifier. A significant, separately identifiable E/M service is
30 defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M
31 service to be reported. If claim history or assigned diagnosis codes do not indicate that significant,
32 separately identifiable services were performed, payers typically cover the primary procedure or
33 other service and deny the secondary E/M billed with modifier 25.

34
35 Some payers have instituted policies where use of modifier 25 triggers an automatic reduction in
36 payment for the second code to account for what they perceive to be “overlap” between the two
37 codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient
38 Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service
39 code at 100 percent and the Office or Other Outpatient code at 50 percent). While the work
40 associated with performing the history, physical examination, and MDM for the problem-oriented
41 E/M service may include some overlap with those performed as part of the comprehensive
42 preventive medicine E/M service, the physician’s use of modifier 25 signals that they performed a
43 significant, separately identifiable problem-oriented E/M service. An insignificant or trivial
44 problem or abnormality is not reported separately from the preventive medicine E/M service.

45
46 Reporting both preventive and problem-oriented E/M services during a single patient encounter can
47 produce inconsistent results in terms of claims payment across payers. While some payers will pay
48 the full allowable amount for both the problem-oriented E/M code and the preventive medicine
49 services E/M code, some will assess a co-pay for each service, some will carve out the payment for
50 the problem-oriented E/M service from the payment for the preventive medicine E/M service
51 (which results in a total charge that does not exceed that of a comprehensive preventive

1 examination alone), and some will reject the claim on the basis that they do not accept coding for
2 both a preventive and problem-oriented service on the same date regardless of the amount of the
3 charge due to the perception of overlap between the two services. In response, physicians may
4 decide to report only one of the services, depending on which of the two is the primary focus of the
5 visit and requires the most amount of physician time and work; however, this is not a tenable
6 solution as it fails to recognize the value of services provided. Alternatively, the physician may ask
7 the patient to return for another visit to address the management of the problem or the preventive
8 care; however, many physicians are hesitant to do this as it places significant burden on patients,
9 particularly those with limited resources, and may risk deterioration of the patient's condition until
10 another appointment can be scheduled.

11

12 Certain payers have considered requiring documentation for all modifier 25 claims. Most recently,
13 Cigna proposed a policy requiring practices to send documentation with "a cover sheet indicating
14 the office notes support the use of modifier 25 appended to the E/M code."¹² While advocacy by
15 the California Medical Association and the AMA was initially able to delay implementation, Cigna
16 has re-released the policy, which was scheduled to become effective in May 2023. At the time this
17 report was written, the AMA was preparing a sign-on letter to allow state medical associations and
18 national medical specialty societies to join in opposition against Cigna's policy. Previous AMA
19 advocacy efforts opposing proposed modifier 25 payment reductions by Anthem (November 2017)
20 and UnitedHealthcare (July 2018) have proven successful.

21

22 Misunderstanding and/or misuse of modifier 25 has made it a top billing compliance risk area. It
23 has been the focus several False Claims Act and civil monetary penalty settlements,¹³ as well as
24 CMS comparative billing reports (CBR). The CMS CBR program is an educational tool intended to
25 encourage accurate reporting and support physicians' internal compliance activities. A CBR tracks
26 a given physician's billing patterns as compared to their peers' patterns within a Medicare service
27 area. Since CBRs are private and shared only with the physician, CMS is able to maintain that
28 "receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a
29 provider's part."¹⁴

30

31 Compliance is impacted by the Medicare Prescription Drug, Improvement, and Modernization Act
32 of 2003 (MMA), which only allows extrapolation of overpayments based on statistical sampling
33 when there's "a determination of sustained or high level of payment error, or documentation that
34 educational intervention has failed to correct the payment error."¹⁵ If an audit does not use a
35 random sample of claims, MMA dictates that extrapolation of that sample invalidates any claim of
36 overpayment.

37

38 AMA POLICY

39

40 The AMA has robust policy to guide advocacy for appropriate payment for multiple services
41 performed during a single patient encounter.

42

43 Among the most relevant policies are those that:

44

- 45 • Focus on recognition of modifier 25 by:
 - 46 • Advocating for the acceptance of CPT modifiers, particularly modifier 25, and the
appropriate alteration of payment based on CPT modifiers (Policy D-70.971);
 - 47 • Aggressively and immediately advocating through any legal means possible to ensure
48 that when an E/M code is reported with modifier 25, that both the procedure and E/M
49 codes are paid at the non-reduced, allowable payment rate (Policy D-385.956);

- 1 • Supporting insurance company payment for E/M services and procedures performed
- 2 on the same day (Policy H-385.944); and
- 3 • Advocating that a CPT code representing a service or procedure that is covered and
- 4 paid for separately should also be paid for when performed at the same time as another
- 5 service or procedure (Policy D-70.959).
- 6
- 7 • Preserve discrete E/M code levels by:
- 8 • Communicating to CMS and private payers that the current levels of E/M services
- 9 should be maintained and not compressed, with appropriate payment for each level
- 10 (Policy D-70.979) and
- 11 • Opposing any health insurance code collapsing policies that result in unfair payment
- 12 practices (Policy H-70.995).
- 13
- 14 • Combat bundling and downcoding by:
- 15 • Opposing the bundling of procedure and laboratory services within the E/M services
- 16 (Policy H-70.985);
- 17 • Opposing the use of time elements to deny or downgrade services submitted based on a
- 18 cumulative time (Policy H-70.976);
- 19 • Advocating to ensure that public and private payers do not bundle services
- 20 inappropriately by encompassing individually coded services under other separately
- 21 coded services (Policy H-70.949);
- 22 • Vigorously opposing the practice of unilateral, arbitrary recoding and/or bundling by
- 23 all payers (Policy H-70.937);
- 24 • Introducing or supporting legislation that would require managed care plans to be
- 25 monitored and prohibited from the arbitrary and inappropriate bundling of services to
- 26 reduce payment (Policy H-70.962); and
- 27 • Working with CMS to provide physician expertise commenting on the medical
- 28 appropriateness of code bundling initiatives for Medicare payment policies (Policy
- 29 • H-70.980).
- 30

31 AMA policy targets payer policies that deviate from CPT guidelines, such as those that:

- 32 • Oppose inappropriate bundling of medical services by third party payers (Policy
- 33 D-70.983);
- 34 • Support the recognition and payment for all CPT codes by all third party payers (Policy
- 35 H-70.974);
- 36 • Seek legislation and/or regulation to ensure that all insurance companies and group payers
- 37 recognize all published CPT codes including modifiers (Policy H-70.954);
- 38 • Intensify efforts to ensure uniform application of coding principles (Policy H-70.986);
- 39 • Assure that CMS and local carriers appropriately reimburse all E/M services (Policy
- 40 H-385.952);
- 41 • Develop national (state) standards and model legislation that require full disclosure in plain
- 42 English of multiple procedure reimbursement policies (Policy H-285.946);
- 43 • Step up ongoing review of the proper use of CPT codes in medical billing claims payments
- 44 by the US Health Insurance Industry (Policy D-385.949);
- 45 • Support the elimination of Medicare arbitrary visit frequency parameters (Policy H-280-
- 46 974); and
- 47 • Pursue proper use of CPT codes, guidelines, and modifiers by software claims editing
- 48 vendors and their customers (Policy H-70.927).

1 Given that CPT is copyrighted by the AMA, there are many policies that support the development,
 2 updating, and maintenance of clinically valid codes in order to accurately reflect current clinical
 3 practice and innovation in medicine, including those that:

- 4 • Work with CMS to continue to refine E/M coding (Policy H-70.961);
- 5 • Advocate that the Department of Health and Human Services designate CPT guidelines
 6 and instructions as contained in the CPT codebook and approved by the CPT Editorial
 7 Panel as the national implementation standards for CPT codes (Policy D-70.987); and
- 8 • Limit future efforts to substantially revise E/M codes to the CPT Editorial Panel (Policy
 9 H-70.921) to appropriately allow the accurate reporting of E/M services provided by all
 10 physicians (Policy H-70.982).

11
 12 AMA policy advocates that payer policies must align with CPT guidelines and reduce the burden
 13 of documentation for E/M services (Policy H-70.952), including opposition to the requirement that
 14 all Level 4 or Level 5 E/M codes require submission of medical record documentation (Policy
 15 D-70.991). Furthermore, AMA policy indicates that payer audit tools must be based on the factors
 16 for arriving at complexity as defined in the CPT codebook (Policy H-70.918).

17
 18 The AMA is invested in ensuring that CPT codes are appropriately valued on the RBRVS via the
 19 RUC process. AMA policy advocates that annually updated and rigorously validated RBRVS
 20 values should provide a basis for physician payment schedules, opposes CMS' policy that reduces
 21 payment for additional surgical procedures after the first procedure by more than 50 percent, and
 22 encourages third party payers and other public programs to utilize the most current CPT codes,
 23 modifiers, and RBRVS relative values (Policy D-400.999). CMS is urged to adopt RUC
 24 recommendations for new and revised CPT codes (Policy H-400.969).

25
 26 AMA policy supports development of CPT educational programs for physicians and health
 27 insurance carriers (Policy H-70.993) and working with national medical specialty societies to
 28 educate their members concerning CPT coding issues (Policy H-70.973). Policy H-400.972 states
 29 that the AMA will take all necessary legal, legislative, and other action to assure that all modifiers
 30 are well publicized and include adequate descriptors.

31
 32 In addition to advocating for compliance with CPT modifier 25 guidelines, AMA policy has
 33 addressed other relevant issues:

- 34 • Recognition of modifiers 54, 55, and 56 for postoperative care of surgical patients (Policy
 35 D-70.955) and modifier 26 to report the professional component separate from the
 36 technical component for the interpretation of laboratory tests (Policy D-70.957);
- 37 • Appropriate payment for office-based procedures (Policy H-330.925), emergency care
 38 (Policy H-130.978), telephone consultations (Policy H-390.889), counseling of serious
 39 medical problems (Policy H-385.977), diagnostic and laboratory panel tests (Policy H-
 40 390.923 and Policy H-70.950), vaccine administration (Policy D-440.937), consultations
 41 (Policy D-70.953 and Policy H-70.939), care plan oversight services (Policy H-70.960),
 42 and after hours services (Policy H-385.940);
- 43 • Delineation of the physician role and responsibility in supervising patient care in non-
 44 office ambulatory settings, including fair and equitable payment for those services (Policy
 45 H-70.991);
- 46 • Insurer recognition of CPT codes that allow primary care physicians to report and receive
 47 payment for physical and behavioral health care services provided on the same date of
 48 service (Policy H-385.915);

- 1 • Development of coding for non-physician services (Policy H-70.994); and
- 2 • Appropriate payment for the additional work and expenses required in treating patients
- 3 during the COVID-19 pandemic (Policy D-390.947).

4
5 DISCUSSION

6
7 There is currently robust infrastructure to allow the reporting of multiple services during a single
8 patient encounter. However, there may be a need to ensure that key stakeholders are well educated
9 on the various reporting options. It is essential that both physicians and payers understand the
10 nuanced concepts involved, such as existing CPT nomenclature, how the RUC process eliminates
11 overlap of physician work and practice expense between services and procedures, and how
12 appropriate reporting and payment for multiple services can lead to greater value to the patient,
13 improved access to care, increased patient satisfaction, and improved overall patient care.

14
15 With the ongoing development of coding resources, it is imperative that CMS align with CPT
16 guidelines in order to reduce potential confusion. For example, CPT and CMS do not presently
17 agree on the interpretation of the Prolonged Service CPT codes, which have a direct bearing on
18 physicians' ability to accurately report multiple services during a single patient encounter. This has
19 resulted in many payers challenging physicians' use of the Prolonged Service codes or denying
20 them all together. As such, the AMA is strongly advocating for alignment of CMS's interpretation
21 of the Prolonged Service codes with the CPT definition. This approach is consistent with past
22 AMA advocacy initiatives, most of which have been successful in reducing the gaps between CMS
23 and CPT.

24
25 A comprehensive education on the appropriate reporting of multiple services should start early in
26 physicians' careers, possibly during residency. A curriculum could focus on concepts such as how
27 to use total visit time to report a higher-level E/M service rather than two E/M codes plus modifier
28 25, allowing them to bypass the administrative rigor imposed by payers who routinely flag
29 modifier 25 claims. It would be ideal if a similar curriculum could be shared with, and undertaken
30 by, the payer community, possibly through organizations such as America's Health Insurance
31 Plans. With these potential resolutions, both "sides" would be cognizant of the guidelines, fostering
32 full transparency between claims submission and claims adjudication.

33
34 As of 2021, 78 percent of office-based physicians used certified EHR systems.¹⁶ Most EHRs
35 include software tools to help physicians determine the appropriate E/M codes for patient
36 encounters and when used correctly, they support accurate coding. However, these EHR-based
37 computer-assisted E/M coding (CAEMC) tools are generally associated with higher levels of E/M
38 coding due to factors such as "cloning" of documentation from the previous visit, which may
39 contribute to restrictive payer policies that require burdensome documentation in order to justify
40 payment. OIG is concerned about EHRs "aiding" providers with coding and documentation
41 decisions, but there has been limited testing of how EHRs capture and use information to
42 recommend E/M codes.

43
44 EHR CAEMC tools are limited in their ability to assist physicians in documenting and reporting
45 multiple services. As such, it may be beneficial for EHR CAEMC tools to be developed to
46 facilitate the appropriate reporting of modifier 25. Such tools might include an algorithm to
47 ascertain the potential areas of perceived overlap between two services, which could then be
48 synchronized to the documentation provided for each service.

1 RECOMMENDATIONS

2

3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 824-I-22, and the remainder of the report be filed:

- 5 1. That our American Medical Association (AMA) support mechanisms to report modifiers
6 appropriately with the least administrative burden possible, including the development of
7 electronic health record tools to facilitate the reporting of multiple, medically necessary
8 services supported by modifier 25. (New HOD Policy)
9
- 10 2. That our AMA support comprehensive education for physicians and insurers on the
11 appropriate use of modifier 25. (New HOD Policy)
12
- 13 3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current
14 Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate
15 alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)
16
- 17 4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and
18 immediately advocate through any legal means possible to ensure that when an evaluation
19 and management (E/M) code is reported with modifier 25, that both the procedure and E/M
20 codes are paid at the non-reduced, allowable payment rate. (Reaffirm HOD Policy)
21
- 22 5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for
23 E/M services and procedures performed on the same day. (Reaffirm HOD Policy)
24
- 25 6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a
26 service or procedure that is covered and paid for separately should also be paid for when
27 performed at the same time as another service or procedure. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-23)

Introduced by: Young Physicians Section

Subject: Updating Physician Job Description for Disability Insurance

Referred to: Reference Committee A

1 Whereas, Many disability insurance products contain language and provisions such as “own
2 occupation” and “own specialty” that may not be consistently defined and whose definitions are
3 not readily available in marketing and policy paperwork; and
4

5 Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles
6 (DOT), the main source of occupational information, in 1938; however, the DOL stopped
7 updating the DOT in 1991¹; and
8

9 Whereas, The DOL and Social Security Administration (SSA) are developing a new
10 Occupational Information System (OIS),² which will replace the DOT as the primary source of
11 occupational information that SSA staff and private insurers commonly use in the disability
12 adjudication process; and
13

14 Whereas, This pandemic has led to many physicians contracting COVID-19 with health care
15 workers and their families, representing up to one-sixth of hospitalized COVID-19 patients³; and
16

17 Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,^{4,5} which
18 can last for a year or more⁶; and
19

20 Whereas, Many with Long COVID cannot return to work on a full time basis⁷ requiring reliance
21 on long-term disability insurance to supplement income; and
22

23 Whereas, While the DOT contains discrete and well-established descriptions of the physical
24 demands of occupations, it does not provide sufficiently specific information on associated
25 mental and cognitive requirements; and
26

27 Whereas, Working with the U.S. Bureau of Labor Statistics allows the SSA the unique
28 opportunity to consider including descriptions of the mental and cognitive requirements of work
29 in the new OIS; and
30

31 Whereas, In the absence of more specific definitions in the disability insurance application,
32 many long-term disability insurers use a “national economy” standard to establish a job
33 description; and
34

35 Whereas, Application of such a national standard may lead to long-term disability denials and
36 financial hardship for physicians; therefore be it
37

38 RESOLVED, That our American Medical Association study the most effective approach to
39 developing specialty-specific job descriptions that reflect the true physical and cognitive
40 demands of each given specialty for use in the Occupational Information System under

- 1 development by the Social Security Administration so as to ensure that physician disability
- 2 policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 3/17/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-23)

Introduced by: Medical Student Section

Subject: Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use

Referred to: Reference Committee A

- 1 Whereas, Medicare Part B spending on physician-administered drugs (PADs), 77% of which are
2 injectable biologics, constitutes a large financial outlay (\$39 billion in 2019) and grew at an
3 average annual rate of 9.7% from 2009 to 2019¹; and
4
- 5 Whereas, Reimbursement for PADs under current Medicare Part B regulations is governed by
6 the “Buy and Bill” system, in which physicians purchase PADs from wholesalers or distributors,
7 stock the drug (incurring the associated inventory costs), and are reimbursed by Medicare (and
8 other commercial insurers) at an amount equal to the Average Sales Price (ASP) of a given
9 drug plus 6% of the ASP^{2,3}; and
10
- 11 Whereas, Currently, each individual manufacturer’s biosimilar are reimbursed at different
12 amounts based on distinct codes, each with a unique ASP⁴; and
13
- 14 Whereas, Health economists and policymakers note that this remuneration structure removes
15 incentives for physicians to pick the least costly version of the drug (and may even incentivize
16 physicians to pick the most expensive drug in a class) when several biosimilars exist, which
17 allows manufacturers to maintain high ASPs and thus results in elevated part B spending^{3,4}; and
18
- 19 Whereas, Biosimilar market penetration is substantially lower in the U.S. than in other high-
20 income countries, in which a large number of biosimilars have been approved and market
21 penetration for approved agents is higher, leading to significant (~60-85%) price reductions⁵;
22 and
23
- 24 Whereas, Medicare Part B’s “buy and bill” regulations drive the use of more costly versions of a
25 biologic (often the originator agent) and may thus reduce the market penetration of additional
26 competitor biosimilars that may be less expensive^{5,6}; and
27
- 28 Whereas, Greater market penetration and competition of biosimilars in the United States could
29 save between \$2 and \$7 billion per year (~1% of total Medicare Part B spending and ~30% of
30 Medicare Part B pharmaceutical expenditure)⁴; and
31
- 32 Whereas, Moving towards a fixed-fee structure may expose losses if the costs of acquiring and
33 storing drugs changes significantly from year to year²; and
34
- 35 Whereas, Allowing the fixed fee to be modifiable and indexed to an appropriate healthcare cost
36 inflation index can ensure that changes to the PAD remuneration policy cover the costs that
37 physicians bear in purchasing and storing PADs, consistent with AMA policy D-330.960⁷; and

1 Whereas, At the N-21 Special Meeting of the House of Delegates, our AMA passed new policy
2 “support[ing] legislation that limits Medicare annual drug price increases to the rate of inflation”;
3 therefore be it
4

5 RESOLVED, That our American Medical Association encourage the Centers for Medicare and
6 Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each
7 comprised of the reference biologic and its biosimilars (based on FDA approvals), to be
8 reimbursed at the same rate to incentivize selection of less expensive PADs while preserving
9 access for patients and reimbursement for physicians; and (b) determine the method rate by
10 which a group of PADs will be reimbursed such that physicians are compensated appropriately
11 for acquisition, inventory, carrying, and administration costs, including but not limited to creating
12 fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of
13 PADs to the rate of inflation. (New HOD Policy)

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

Received: 3/27/23

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7. AMA Policy Finder. Cuts in Medicare Outpatient Infusion Services. D-330.960

RELEVANT AMA POLICY

Cuts in Medicare Outpatient Infusion Services D-330.960

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.

2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Citation: Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.

2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.

3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.

4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Citation: Res. 241, A-16;

Medicare Part B Competitive Acquisition Program (CAP) H-110.983

Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- (1) it must be genuinely voluntary and not penalize practices that choose not to participate;
- (2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
- (3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
- (4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
- (5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- (6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
- (7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
- (8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

Citation: Res. 216, I-18; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 4, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-23)

Introduced by: Medical Student Section

Subject: Movement Away from Employer-Sponsored Health Insurance

Referred to: Reference Committee A

- 1 Whereas, More than 50% of Americans rely on employer-sponsored health insurance (ESHI),
2 which was first offered as a benefit to attract workers during the wage freeze of WWII^{1,2}; and
3
- 4 Whereas, With health insurance linked to employment, job loss can decrease access to
5 healthcare, including important preventative services and chronic disease management^{3,4}; and
6
- 7 Whereas, Economic downturns due to global recessions or pandemics can result in millions of
8 people losing their employer-sponsored health insurance, including an estimated 7 million
9 individuals who have lost ESHI due to the COVID-19 pandemic and associated recession⁵⁻¹¹;
10 and
11
- 12 Whereas, Due to variation in insurer networks, patients who switch jobs and as a result change
13 their health insurance may have to change doctors, creating a barrier to continuity of care^{12,13};
14 and
15
- 16 Whereas, In 2019, 36% of employers offered only a single health insurance plan and an
17 additional 40% of employers offered only two plans, decreasing patient choice and preventing
18 the functioning of a free market¹⁴⁻¹⁶; and
19
- 20 Whereas, By linking health insurance to employment, employer-sponsored health insurance
21 creates job lock and decreases entrepreneurship^{17,18}; and
22
- 23 Whereas, A 2016 study in the Journal of Economic Perspectives found that people in the
24 bottom fifth of family income receive annual benefits of less than \$500, while those in the top
25 fifth receive benefits averaging \$4,500, demonstrating that employer-sponsored health
26 insurance tax deduction disproportionately benefits the wealthy¹⁹; and
27
- 28 Whereas, Self-insurance refers to the practice wherein employers collect premiums from
29 employees and pay for healthcare benefits for plan beneficiaries directly, with or without the
30 assistance of third party administrators who may negotiate networks, process claims, and
31 provide other services^{20,21}; and
32
- 33 Whereas, Because of financial and legal incentives that favor the practice, between 75-80% of
34 employers self-insure, meaning that many firms become de facto health insurance companies in
35 addition to the main business activities they are engaged in^{22,23}; and
36
- 37 Whereas, Self-insured plans have proven incapable of controlling healthcare costs, with one
38 RAND study focusing on predominantly self-insured employer plans showing that hospital costs
39 increased from 236% of Medicare rates to 241% of Medicare rates in the two year period from
40 2015-2017^{23,24}; and

1 Whereas, The administrative costs of private, employer-based plans far exceed the
2 administrative costs of public plans in the United States and insurance systems in other
3 industrialized peer nations²⁵⁻²⁹; and
4

5 Whereas, The excessively fragmented nature of the employer-sponsored health insurance
6 market in the United States is a significant contributor to the higher costs of medical goods and
7 services in the United States relative to other countries²⁹⁻³¹; and
8

9 Whereas, Multiple different models exist for the provision of health insurance coverage,
10 including systems based wholly on individually owned private insurance plans, the Bismarckian
11 model wherein payroll taxes are used to fund competing nonprofit insurance providers, and the
12 national health insurance model wherein government insurance plans funded by taxes contract
13 with privately owned healthcare providers^{32,33}; and
14

15 Whereas, All of the assorted health insurance systems employed in other industrialized
16 countries outperform the ESHI-based American insurance system on key metrics such as health
17 outcomes, cost, and administrative efficiency^{29,30,34-36}; and
18

19 Whereas, Under the Affordable Care Act, patients who are offered an “affordable” ESHI plan
20 that meets the minimum value standard are ineligible to receive premium tax credits and cost
21 sharing reductions (a requirement known as the “ESHI firewall”), thus significantly impairing
22 their ability to buy a plan on the ACA’s Health Insurance Marketplaces at an affordable rate³⁷;
23 and
24

25 Whereas, An ESHI plans needs to cover only 60% of the total cost of expected healthcare
26 expenses to meet the minimum value standard, leaving up to 40% of these costs to be covered
27 by the patient³⁷; and
28

29 Whereas, A survey of employer-sponsored health insurance beneficiaries conducted by the
30 Kaiser Family Foundation in 2019 found that over 40% of beneficiaries had difficulty paying for
31 some aspect of their coverage, including the premium, deductibles, or other expenditures³⁸; and
32

33 Whereas, Under current law, the cost of individual ESHI coverage is exclusively used to
34 calculate plan affordability even if the employee wants to or needs to purchase a family plan,
35 meaning that millions of Americans are ineligible for premium tax credits but may also be unable
36 to afford a plan through their employer³⁹⁻⁴²; and
37

38 Whereas, Eliminating the ESHI firewall would allow individuals who are offered ESHI to still be
39 eligible for premium tax credits and cost sharing reductions, thus enabling them to choose a
40 plan that is the most affordable and best meets their needs from either their employer-
41 sponsored plans or other plans offered on their state’s Health Insurance Marketplace^{43,44}; and
42

43 Whereas, Roughly 10-20 million Americans with ESHI could choose a plan on the ACA
44 Exchanges with lower premiums than their current employer-based plan if the ESHI firewall
45 were eliminated^{44,45}; and
46

47 Whereas, In 2017, 2.7 million uninsured Americans who otherwise would be eligible for
48 premium tax credits to lower the cost of insurance coverage were ineligible for those tax credits
49 because of an offer of ESHI⁴⁶; and

1 Whereas, Removing the ESHI firewall could contribute to substantial insurance coverage gains
2 by making insurance options on the ACA Exchanges significantly more affordable for individuals
3 who may not be able to afford insurance offered through their employer⁴⁷⁻⁵⁰; and
4

5 Whereas, The American Medical Association “supports individually selected and individually-
6 owned health insurance as the preferred method for people to obtain health insurance
7 coverage” (Policy H-165.920), but has not recognized the deficiencies of the employer-
8 sponsored insurance system, nor the need to move towards a health insurance system that
9 does not rely on employer-sponsored insurance; therefore be it

10
11 RESOLVED, That our American Medical Association recognize the inefficiencies and
12 complexity of the employer-sponsored health insurance system and the existence of alternative
13 models that better align incentives to facilitate access to high quality healthcare (New HOD
14 Policy); and be it further

15
16 RESOLVED, That our AMA support movement toward a healthcare system that does not rely
17 on employer-sponsored health insurance and enables universal access to high quality
18 healthcare (New HOD Policy); and be it further

19
20 RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability”, by
21 addition and deletion to read as follows:
22

23 **HEALTH INSURANCE AFFORDABILITY, H-165.828**

24 1. ~~Our AMA supports modifying the eligibility criteria for premium~~
25 ~~credits and cost-sharing subsidies for those offered employer-~~
26 ~~sponsored coverage by lowering the threshold that determines~~
27 ~~whether an employee's premium contribution is affordable to that~~
28 ~~which applies to the exemption from the individual mandate of the~~
29 ~~Affordable Care Act (ACA). Our AMA advocates for the elimination of~~
30 ~~the employer-sponsored insurance firewall such that no individual~~
31 ~~would be ineligible for premium tax credits and cost-sharing~~
32 ~~assistance for marketplace coverage solely on the basis of having~~
33 ~~access to employer-sponsored health insurance.~~

34 2. Our AMA supports legislation or regulation, whichever is relevant,
35 to fix the ACA's "family glitch," thus determining the affordability of
36 employer-sponsored coverage with respect to the cost of family-
37 based or employee-only coverage.

38 3. Our AMA encourages the development of demonstration projects
39 to allow individuals eligible for cost-sharing subsidies, who forego
40 these subsidies by enrolling in a bronze plan, to have access to a
41 health savings account (HSA) partially funded by an amount
42 determined to be equivalent to the cost-sharing subsidy.

43 4. Our AMA supports capping the tax exclusion for employment-
44 based health insurance as a funding stream to improve health
45 insurance affordability, including for individuals impacted by the
46 inconsistency in affordability definitions, individuals impacted by the
47 "family glitch," and individuals who forego cost-sharing subsidies
48 despite being eligible.

49 5. Our AMA supports additional education regarding deductibles and
50 cost-sharing at the time of health plan enrollment, including through
51 the use of online prompts and the provision of examples of patient
52 cost-sharing responsibilities for common procedures and services.

- 1 6. Our AMA supports efforts to ensure clear and meaningful
2 differences between plans offered on health insurance exchanges.
3 7. Our AMA supports clear labeling of exchange plans that are
4 eligible to be paired with a Health Savings Account (HSA) with
5 information on how to set up an HSA.
6 8. Our AMA supports the inclusion of pregnancy as a qualifying life
7 event for special enrollment in the health insurance marketplace.
8 (Modify Current HOD Policy) and be it further
9

10 RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the
11 AMA Proposal for Reform", by deletion to read as follows:

12
13 **OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA**
14 **PROPOSAL FOR REFORM, H-165.823**

- 15 1. That our AMA advocate for a pluralistic health care system, which
16 may include a public option, that focuses on increasing equity and
17 access, is cost-conscious, and reduces burden on physicians.
18 2. Our AMA will advocate that any public option to expand health
19 insurance coverage must meet the following standards:
20 a. The primary goals of establishing a public option are to maximize
21 patient choice of health plan and maximize health plan marketplace
22 competition.
23 ~~b. Eligibility for premium tax credit and cost sharing assistance to~~
24 ~~purchase the public option is restricted to individuals without access~~
25 ~~to affordable employer-sponsored coverage that meets standards for~~
26 ~~minimum value of benefits.~~
27 be. Physician payments under the public option are established
28 through meaningful negotiations and contracts. Physician payments
29 under the public option must be higher than prevailing Medicare
30 rates and at rates sufficient to sustain the costs of medical practice.
31 cd. Physicians have the freedom to choose whether to participate in
32 the public option. Public option proposals should not require provider
33 participation and/or tie physician participation in Medicare, Medicaid
34 and/or any commercial product to participation in the public option.
35 de. The public option is financially self-sustaining and has uniform
36 solvency requirements.
37 ef. The public option does not receive advantageous government
38 subsidies in comparison to those provided to other health plans.
39 fg. The public option shall be made available to uninsured individuals
40 who fall into the "coverage gap" in states that do not expand
41 Medicaid – having incomes above Medicaid eligibility limits but below
42 the federal poverty level, which is the lower limit for premium tax
43 credits – at no or nominal cost.
44 3. Our AMA supports states and/or the federal government pursuing
45 auto-enrollment in health insurance coverage that meets the
46 following standards:
47 a. Individuals must provide consent to the applicable state and/or
48 federal entities to share their health insurance status and tax data
49 with the entity with the authority to make coverage determinations.
50 b. Individuals should only be auto-enrolled in health insurance
51 coverage if they are eligible for coverage options that would be of no
52 cost to them after the application of any subsidies. Candidates for

1 auto-enrollment would, therefore, include individuals eligible for
2 Medicaid/Children’s Health Insurance Program (CHIP) or zero-
3 premium marketplace coverage.

4 c. Individuals should have the opportunity to opt out from health
5 insurance coverage into which they are auto-enrolled.

6 d. Individuals should not be penalized if they are auto-enrolled into
7 coverage for which they are not eligible or remain uninsured despite
8 believing they were enrolled in health insurance coverage via auto-
9 enrollment.

10 e. Individuals eligible for zero-premium marketplace coverage should
11 be randomly assigned among the zero-premium plans with the
12 highest actuarial values.

13 f. Health plans should be incentivized to offer pre-deductible
14 coverage including physician services in their bronze and silver
15 plans, to maximize the value of zero-premium plans to plan
16 enrollees.

17 g. Individuals enrolled in a zero-premium bronze plan who are
18 eligible for cost-sharing reductions should be notified of the cost-
19 sharing advantages of enrolling in silver plans.

20 h. There should be targeted outreach and streamlined enrollment
21 mechanisms promoting health insurance enrollment, which could
22 include raising awareness of the availability of premium tax credits
23 and cost-sharing reductions, and establishing a special enrollment
24 period.

25 4. Our AMA: (a) will advocate that any federal approach to cover
26 uninsured individuals who fall into the “coverage gap” in states that
27 do not expand Medicaid--having incomes above Medicaid eligibility
28 limits but below the federal poverty level, which is the lower limit for
29 premium tax credit eligibility--make health insurance coverage
30 available to uninsured individuals who fall into the coverage gap at
31 no or nominal cost, with significant cost-sharing protections; (b) will
32 advocate that any federal approach to cover uninsured individuals
33 who fall into the coverage gap provide states that have already
34 implemented Medicaid expansions with additional incentives to
35 maintain their expansions; (c) supports extending eligibility to
36 purchase Affordable Care Act (ACA) marketplace coverage to
37 undocumented immigrants and Deferred Action for Childhood
38 Arrivals (DACA) recipients, with the guarantee that health plans and
39 ACA marketplaces will not collect and/or report data regarding
40 enrollee immigration status; and (d) recognizes the potential for state
41 and local initiatives to provide coverage to immigrants without regard
42 to immigration status. (Modify Current HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Individual Health Insurance H-165.920

Our AMA:

- (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
- (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite

resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:

(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;

(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and

(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.

Citation: BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97;

Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17;

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22;

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
 - A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
 - B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
 - C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
 - D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
 - E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
 - F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
 - G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
 - H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep. 1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17;

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

- a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
- b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
- c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
- d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
- e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-23)

Introduced by: Medical Student Section

Subject: Support for Medicare Expansion to Wheelchair Accessibility Home
Modifications as Durable Medical Equipment

Referred to: Reference Committee A

- 1 Whereas, The 2010 United States Census reported that 3.6 million individuals utilize a
2 wheelchair and 11.6 million used a cane, crutches or walker to assist with ambulation¹; and
3
4 Whereas, A report from the U.S. Department of Housing and Urban Development Office of
5 Policy Development and Research reports that 89.2% of persons with disability live in
6 inaccessible housing²; and
7
8 Whereas, Over 50% of households with a resident reliant on wheeled mobility equipment have
9 homes with stairs at the front entrance that may inhibit their ability to freely enter their home²;
10 and
11
12 Whereas, The United Nations Convention on the Rights of Persons with Disabilities, Article 9
13 safeguards the right of persons with disabilities to live in an accessible environment⁵; and
14
15 Whereas, A Joint Statement by the Department of Justice and Department of Housing and
16 Urban Development on the Fair Housing Act requires that passage into and within all premises
17 of covered dwellings may have an accessible route for wheelchair users¹⁴; and
18
19 Whereas, The Fair Housing Act also require usable kitchen and bathrooms such that an
20 individual using a wheelchair can maneuver about and use this space¹⁴; and
21
22 Whereas, One study noted that 16% of injuries from wheelchair accidents from falls required
23 medical intervention, most commonly for fractures and concussions³; and
24
25 Whereas, A study that employed wheeled mobility device users found that 90% of participants
26 reported that their participation was limited when surfaces higher than their wheeled device
27 were encountered, indicating the value that wheelchair ramps can provide¹²; and
28
29 Whereas, Researchers at the National Disability Institute found that on average households
30 containing an adult with a physical disability required 28% more income, or an additional
31 \$17,690 a year to obtain the same standard of living^{4,11}; and
32
33 Whereas, Medicare Part B covers medically necessary equipment defined as Durable Medical
34 Equipment including wheelchairs, scooters, traction equipment, however not including
35 wheelchair ramps as medically necessary¹³; and
36
37 Whereas, A single-blind randomized controlled trial in New Zealand found a 31% reduction in
38 the rate of fall injuries at home per year following home stairs modification intervention
39 compared with households in the control group without home modification⁷; and

1 Whereas, A study that assessed the factors that influence the risk of falling after spinal cord
2 injury found lack of necessary home modification to be a major determinant⁹; and
3

4 Whereas, Spinal cord injury patient participants in the 2020 BMJ Open study noted that
5 “egregious cost of home modifications” are reason for lack of proper accommodations and
6 increased incidence of fall⁹; and
7

8 Whereas, Independence in mobility, as provided by necessary wheelchair home modifications,
9 has been deemed a key factor in preserving function and maintaining life satisfaction among
10 wheelchair users^{6,8,10}; therefore be it
11

12 RESOLVED, That our American Medical Association support that Medicare Part B cover
13 wheelchair ramps and associated home installation for beneficiaries for whom using a
14 wheelchair at home is "medically necessary." (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Support for Housing Modification Policies H-160.890

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907

Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Citation: (Res. 816, I-15)

Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899

Our AMA will request that the Centers for Medicare and Medicaid Services render a benefit category determination that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment when used in a power wheelchair.

Citation: Res. 808, I-19;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Citation: Res. 814, I-17;

Community Mobility Devices H-90.978

The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients.

Citation: CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-23)

Introduced by: Medical Student Section

Subject: Studying Population-Based Payment Policy Disparities

Referred to: Reference Committee A

1 Whereas, Certain fields of medicine care for distinct patient populations, such as pediatrics,
2 obstetrics and gynecology (OBGYN), geriatrics, infectious disease, urology, addiction medicine,
3 sports medicine, etc.; and
4

5 Whereas, Procedures performed for specialized patient populations such as gynecology
6 patients have been shown to be reimbursed at lower rates than those for other specialized
7 patient populations such as urology patients, despite being similar in nature¹; and
8

9 Whereas, The Medicare fee schedule is a leading cause of reimbursement imbalance between
10 specialties due to documented factors, such as discrepancies in valuation of surgical
11 intraoperative time, and different valuation of procedural and physical effort to cognitive effort²;
12 and
13

14 Whereas, There is evidence to suggest that current work Relative Value Units (RVUs) are
15 misvalued as changes in work RVUs have not reflected changes in technology in some
16 specialties with undervaluation in cognitive effort, such as the management of complex
17 conditions by primary care providers^{3,4}; and
18

19 Whereas, In comparison to higher paid specialties, lower paid specialties with a single physician
20 serving Medicare recipients are more likely to be completely absent in a given county, such that
21 92% of counties lack an addiction medicine physician and 80% of counties lack an infectious
22 disease specialist⁵; and
23

24 Whereas, Access to care for mental health has persisted as an issue due to provider availability
25 and reimbursement incentives⁶; and
26

27 Whereas, Documented racial disparities in reimbursement rates demonstrate statistically
28 significant lower mean reimbursement per RVU for insured black patients within a tertiary
29 hospital Emergency Department compared to their white counterparts, after adjusting for
30 demographic and insurance factors⁷; and
31

32 Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that
33 procedures predominantly done on men were associated with higher RVUs and compensated at
34 a rate 26.67% higher than procedures done predominantly on women¹; and
35

36 Whereas, Disparity in RVUs reimbursed for similar procedures performed predominantly on
37 women versus men has minimally decreased from 1997 to 2015, with a study reporting 42 of 50
38 (84%) male-based urologic procedures compensated at a higher rate than the paired female
39 urologic procedures¹; and

1 Whereas, OBGYN physicians work comparable hours and perform many surgical procedures
2 similar in number and complexity to other surgical specialties, yet their pay is the lowest
3 amongst all surgical specialties; leading to an estimated OBGYN physician shortage of 17% by
4 2030, 24% by 2040, and 31% by 2050^{8,9}; and

5
6 Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of
7 internal medicine subspecialists, contributing to a high percentage of vacant seats across
8 pediatric fellowship programs and a resulting shortage of pediatric subspecialists¹⁰⁻¹²; and

9
10 Whereas, The compensation of pediatric sub-specialists is lower than general pediatricians, de-
11 incentivizing trainees to pursue fellowships in that realm, with a study finding the salary of
12 pediatric endocrinologists to be 10% lower than that of general pediatricians¹³⁻¹⁵; and

13
14 Whereas, Pediatric infectious disease specialists experience the lowest compensation of all
15 physicians, earning \$191,735 compared to \$265,000 earned by adult infectious disease
16 specialists¹³⁻¹⁵; and

17
18 Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled
19 seats; for example, 40.6% of pediatric nephrologist fellowship seats were not filled in 2019,
20 indicating both trainee disinterest and a lack of provider availability, which can negatively impact
21 access to care and contribute to longer wait times^{10,16}; and

22
23 Whereas, Medicare and Medicaid often function as a safety net for hospitals by reimbursing
24 institutions for expenses of hospitalizations not paid by patients themselves, and often falls short
25 of covering the hospitals' care-delivery costs^{17,18}; and

26
27 Whereas, Lower reimbursements for specialties that care for certain underserved patient
28 populations may disincentivize physicians from entering those specialties and providing care for
29 the corresponding patient populations, or disincentivize hospitals to provide such care^{19,20}; and

30
31 Whereas, Not only is the ratio of specialists to primary care physicians (PCP) higher in the U.S.
32 than in other countries, it has been documented by studies as being due to U.S. ratio of
33 specialist to PCP compensation rates exceeding other countries' specialist to PCP
34 compensation rates²¹⁻²⁴; and

35
36 Whereas, An American College of Physicians position statement holds that "Medicare and other
37 payers should adopt population-based, prospective payment models for primary and
38 comprehensive care that are structured and sufficient to ensure access to needed care and
39 address the needs of individuals experiencing health care disparities and inequities based on
40 personal characteristics and/or are disproportionately affected by social drivers of health. Hybrid
41 models combining fee-for-service with prospective payment should be made available and
42 should prioritize the needs of such individuals"²⁵; and

43
44 Whereas, The Center for Medicare Services' most recent publication of the Medicare payment
45 schedule came with an official solicitation for comments on how the agency can advance health
46 equity for people with Medicare²⁶; and

47
48 Whereas, The National Academy of Medicine Committee for Medicare recommends a potential
49 policy remedy to use reimbursements to incentivize care for underserved populations: a per-
50 patient payment adjustment for patients' social risks, deliberately connected to the quality of
51 patient outcomes; an approach that requires separate reporting of quality measures for

1 hospitals in different categories related to distinct levels of social risk in the populations they
2 serve and includes an additional financial incentive for quality improvement^{27,28}; and

3
4 Whereas, Financial incentives can reward hospitals for incremental improvements in quality
5 measures against their own historical benchmarks, and promote closing gaps in the quality of
6 care that may be worse among institutions primarily serving disadvantaged populations^{27,28}; and

7
8 Whereas, Anchor institutions are (organizations that commit themselves to hiring, procuring,
9 and investing in disadvantaged communities) and would earn enriched reimbursement for the
10 patients they serve from those same or similarly disadvantaged communities²⁹; and

11
12 Whereas, Another policy alternative to use reimbursement to promote care for underserved
13 populations is to promote hospitals that achieve certain metrics in key domains to be qualified
14 as anchor institutions²⁹; and

15
16 Whereas, A study found that the choice of a higher-income specialty was associated with lower
17 burnout (OR = 0.56, 95% CI 0.32-0.98)³⁰; and

18
19 Whereas, Medical students have indicated difficulty in completing loan repayments due to
20 increasing tuition rates and lack of financial compensation as deterrents to entering certain
21 fields and caring for certain populations^{25, 31}; and

22
23 Whereas, Nearly half (48%) of graduating medical students cite income as a strong or moderate
24 influence on their decision to pursue a certain specialty, and only 20% stated that it has no
25 influence on their decision of which specialty to choose²⁰; and

26
27 Whereas, Current AMA Policy H-65.961 states that the AMA “declares that compensation
28 should be equitable and based on demonstrated competencies and expertise and not based on
29 personal characteristics,” which can include the type of population a physician serves or the
30 specialty they practice; therefore be it

31
32 RESOLVED, That our American Medical Association study opportunities to incentivize
33 physicians to select specialties and practice settings which involve delivery of health services to
34 populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children,
35 elder adults, and patients with disabilities, including populations of such patients who do not live
36 in underserved geographic areas (Directive to Take Action); and be it further

37
38 RESOLVED, That our AMA study the effects of factors such as valuation and reimbursement
39 rates on physician choice of specialty, degree of institutional support, workforce shortages,
40 burnout, and attrition, especially in specialties and practice settings that primarily care for
41 underserved populations. (Directive to Take Action)

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

Received: 3/27/23

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RELEVANT AMA POLICY

E9.5.5 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.

Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961

Principles for Advancing Gender Equity in Medicine:

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

3. endorses the principle of equal opportunity of employment and practice in the medical field;

4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;

6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Citation: BOT Rep. 27, A-19;

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
 2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
 3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
 4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
 5. Our AMA will: (a) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; and (b) work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.
- Citation: Res. 010, A-18; Modified: BOT Rep. 27, A-19; Appended: Res. 615, A-22;

Medical Care of Persons with Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be

guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision.

Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

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

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

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

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

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

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

10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.

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

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22;

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to

reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18;

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Citation: Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19;

Adequate Physician Reimbursement for Long-Term Care H-280.979

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;

(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;

(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and

(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.

Citation: Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;

(2) which proprietary "correct coding" CPT bundling program is employed;

(3) grievance and appeal mechanisms;

(4) conditions under which a contract can be terminated by a physician or health plan;

(5) patient confidentiality protections;

(6) policies on patient referrals and physician use of consultants;

(7) a current listing by name and specialty of the physicians participating in the plan; and

(8) a current listing by name of the ancillary service providers participating in the plan.

Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18;

Cuts in Medicare and Medicaid Reimbursement H-330.932

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00;

Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00;

Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21;

Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917

(1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.

Citation: Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18;

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical

providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Citation: Res. 814, I-17;

RVS Updating H-400.969

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

Citation: (BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15)

Guidelines for the Resource-Based Relative Value Scale H-400.991

(1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)

(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

Citation: BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: Res. 212, I-21;

Non- Medicare Use of the RBRVS D-400.999

Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; (2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale; (3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies; (4) strongly oppose and protests the Centers for Medicare & Medicaid Services Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS.

Citation: CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17;

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Citation: Res. 005, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-23)

Introduced by: Medical Student Section

Subject: Billing for Traditional Healing Services

Referred to: Reference Committee A

1 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health
2 and Human Services, is responsible for providing health services to American Indians and
3 Alaska Natives (AI/AN), as a federal trust responsibility and treaty obligations to American
4 Indian and Alaska Native Tribes and Villages¹⁻²; and

5
6 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita
7 health care expenditures are \$4,078, while figures for Medicaid and Medicare are \$8,109 and
8 \$13,185, respectively³; and

9
10 Whereas, The IHS is considered the payor of last resort and is only utilized after other
11 federal, state, local, or private source of reimbursement for which the patient is eligible have
12 been exhausted⁴; and

13
14 Whereas, Reimbursement sources utilized before IHS payment include, but are not limited to,
15 Medicare Part A and B, State Medicaid, State or other federal health programs (e.g.,
16 Veterans Health Administration), private insurance, and funds from Tribal health programs⁴;
17 and

18
19 Whereas, Payments for IHS patients' medical care received from public programs such as
20 Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal
21 year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities⁵; and

22
23 Whereas, Third-party collections are increasingly important, representing a significant portion
24 of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget, and also used
25 to procure services, supplies, and pharmaceuticals⁵; and

26
27 Whereas, The IHS, through offerings of Western medicine and traditional healing services,
28 works to ensure that culturally-appropriate health care services are available and accessible
29 to AI/AN patients⁶; and

30
31 Whereas, Traditional medicine is the sum total of the knowledge, skills, and practices based
32 on the theories, beliefs, and experiences specific to different cultures, whether explicable or
33 not, used in the maintenance of health as well as in the prevention, diagnosis, improvement
34 or treatment of physical and mental illness⁷; and

35
36 Whereas, In a survey of 150 AI/AN patients at one Urban Indian Health Program, 38%
37 reported seeking medical care from both a physician and a traditional healer in their
38 community⁸; and

1 Whereas, In another rural, reservation-based setting of 2,595 AI/AN adolescents and adults,
2 41 to 60% sought biomedical services for physical health concerns; 8 to 23% sought
3 traditional healing services for physical health concerns; and 10-23% used Western and
4 traditional healing services, while 3 to 40% used only traditional healing⁹; and
5

6 Whereas, Among AI/AN patients who see both a physician and a traditional healer, more
7 than half (61.4%) trust the advice of their traditional healer(s) over their physician, and may
8 also limit disclosure of their medical history due to medical distrust and poor coordination of
9 care^{8,10}; and
10

11 Whereas, The American Medical Association recognizes the "medicine man" and other
12 traditional healing figures as an integral and culturally necessary part in delivering health care
13 to AI/AN patients (H-350.976); and
14

15 Whereas, A study evaluating the efficacy of many traditional Cherokee medicines found that
16 their use was efficient for treating intended illness, and was adopted by European settlers
17 following their introduction to them¹¹; and
18

19 Whereas, Connections to traditional culture, including food, has a positive impact on spiritual
20 and physical health and decreases rates of chronic disease within AI/AN populations^{12,13}; and
21

22 Whereas, The Alaska Native Medical Center, the major referral unit for AI/AN patients within
23 the state of Alaska, offers a Traditional Healing Clinic in conjunction with other health
24 services to provide whole-person care to patients¹⁴; and
25

26 Whereas, The IHS cannot bill private insurance and state Medicaid programs and Medicaid
27 managed care organizations for traditional healing services, limiting reimbursement for and
28 implementation of traditional healing services at IHS, Tribal, and Urban Indian health
29 facilities¹⁵; and
30

31 Whereas, Traditional healing practices and knowledge are widely considered sacred and not
32 shared with outside healthcare practitioners¹⁶; and
33

34 Whereas, The diversity of traditional healing practices between AI/AN Tribes and Villages
35 creates challenges for creating medical billing codes and reimbursement processes; and
36

37 Whereas, The state of Arizona, in consultation with Tribes, is seeking Section 1115
38 demonstration authority to cover traditional healing services furnished by the IHS to AI/AN
39 Medicaid enrollees¹⁷⁻¹⁸; and
40

41 Whereas, The proposed Arizona Section 1115 Medicaid waiver for traditional healing
42 services would (1) allow IHS, Tribal, and Urban Indian Health Programs and AI/AN Tribes
43 and Villages designate and contract with traditional healing providers; (2) coordinate medical
44 care and traditional healing delivery to prevent medical contraindications; and (3) require
45 patient evaluation of traditional healing services¹⁸; and
46

47 Whereas, While the IHS and Congress have long noted their acceptance and respect for
48 AI/AN traditional healing services, the Indian Health Care Improvement Act does not explicitly
49 define or authorize traditional healing services to be paid for by the IHS¹⁷⁻¹⁹; therefore be it

- 1 RESOLVED, That our American Medical Association study the impact of Medicaid waivers
- 2 for managed care demonstration projects regarding implementation and reimbursement for
- 3 traditional American Indian and Alaska Native healing practices provided in concert with
- 4 physician-led healthcare teams. (Directive to Take Action)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and

establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Unconventional Medical Care in the United States H-480.973

Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.

Citation: BOT Rep. 15, A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.

4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):

a. Continue to expand technical assistance;

b. Develop IT systems that support and streamline clinical participation;

c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;

d. Identify methods to reduce the data collection burden; and

e. Begin implementing the 21st Century Cures Act.

5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:

a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;

b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and

c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.

6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:

a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;

b. Distinguish between services ordered by a physician and those delivered by a physician;

- c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patients and physicians responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
- a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.

Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19;
Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-23)

Introduced by: Medical Student Section

Subject: Reducing the Cost of Centers for Medicare and Medicaid Services Limited
Data Sets for Academic Use

Referred to: Reference Committee A

1 Whereas, Free and affordable sharing of research data among scientists has been shown to
2 confer numerous benefits in the advancement of scientific progress¹⁻³; and
3
4 Whereas, Limited data sets are defined as those registries and databases that adhere to the
5 Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are
6 stripped of all direct patient identifiers and protected health information (PHI)^{4,5}; and
7
8 Whereas, The Centers for Medicare and Medicaid Services (CMS) currently maintains de-
9 identified limited data sets that contain outcome, demographic, comorbidity, and cost data for
10 millions of patients across the United States, which have been instrumental in conducting high-
11 quality, population-wide research⁶⁻⁸; and
12
13 Whereas, Many of these data files, which are already subsidized by taxpayer dollars, can cost
14 tens of thousands of dollars per year of data to acquire, an expense that poses a significant
15 financial barrier to academic and non-profit organizations^{6,9}; and
16
17 Whereas, There is currently no written justification for these prices on the CMS website^{6,10,11};
18 and
19
20 Whereas, Increasing academic and non-profit access to larger datasets for scholarly purposes
21 would greatly increase the sample size, relevance, and power of future studies; and
22
23 Whereas, Lowering the cost of this data for academic and non-profit users, and offsetting the
24 resulting loss in revenue with increased prices for for-profit and corporate entities, would aid in
25 increasing access to this data for research purposes⁹; and
26
27 Whereas, A tiered pricing scheme (i.e. higher prices for commercial users and lower prices for
28 non-commercial users) has already been implemented in other countries such as the United
29 Kingdom^{12,13}; therefore be it
30
31 RESOLVED, That our American Medical Association encourage the Centers for Medicare and
32 Medicaid Services to adjust the pricing of limited data sets in order to increase access for
33 academic use. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Medicare Claims Data Release D-406.993

Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; (2) engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs; (3) petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public; and (4) in an effort to advance the feasibility of population health research to fulfill the promise of value based care, will request that CMS eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations that are contained in the CMS Data Use Agreement and allow sharing of that data: (a) in the form of de-identified data sets as permitted by federal, state, and local privacy laws; and (b) for purposes of research as permitted by federal, state, and local privacy laws.

Citation: Sub. Res. 204, A-14; Appended: Res. 226, A-17; Appended: Res. 241, A-19;

Work of the Task Force on the Release of Physician Data H-406.990

Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
 - (a) the publication or release of this information is deemed imperative to safeguard the public welfare;
 - (b) the raw data regarding physician claims from governmental healthcare programs is:
 - (i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
 - (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
 - (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
 - (i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
 - (ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
 - (iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
 - (d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.

Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19;

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician

profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution

errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

Citation: BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-23)

Introduced by: District of Columbia

Subject: Sustainable Reimbursement for Community Practices

Referred to: Reference Committee A

- 1 Whereas, Community-based private practices accept insurance reimbursement to provide
2 access to affordable service for people in need; and
3
- 4 Whereas, Small private practices provide neighborhood-based care, often in communities facing
5 health disparities, that may not be readily available elsewhere; and
6
- 7 Whereas, Medicare rates are collaboratively (by AMA, government agencies, and industry)
8 based on the resource-based relative value scale, created by Harvard University in 1985 and
9 published in the *Journal of the American Medical Association* in 1988¹, which incorporates
10 physician work, practice expense, professional liability costs, and geographic variations, with
11 extensive input from physicians and specialty societies; and
12
- 13 Whereas, Reimbursement from private insurers to small practices is often well below Medicare
14 rates and below the level required to cover fixed costs and accompanied by a dramatic increase
15 in required reporting by physician offices; and
16
- 17 Whereas, There are currently no lower limits regarding the reimbursement rates insurers pay to
18 medical practices and no legal requirements that insurers negotiate with practices, provide fair
19 reimbursement, or consider the needs of patients served by community practices; and
20
- 21 Whereas, Payers may refuse to negotiate appropriate reimbursement rates with small private
22 practices; and
23
- 24 Whereas, Private practices are rapidly disappearing, either going out of business or being
25 absorbed by large institutional practices that are able to negotiate with payers (as of January
26 2021, nearly 70 percent of U.S. physicians reportedly worked for hospitals or corporate
27 entities²); and
28
- 29 Whereas, AMA policy supports a pluralistic approach to health care utilization to include small,
30 solo, and medium-sized practices. Despite the well documented outcome-based evidence of the
31 benefit of these treatment options, third-party insurers are forcing market consolidation with
32 unsustainable reimbursement models that are below Medicare reimbursement rates; and
33
- 34 Whereas, Private practices are prohibited from collaborating with each other to request fair
35 reimbursement due to prior anti-trust legal interpretations; and
36
- 37 Whereas, The future of health care is trending towards the concepts of population health
38 management, outcome evidence-based care, and value-based purchasing of health care.
39 These models favor large groups and hospitals, once again excluding private practice
40 physicians in small and medium-sized groups. The AMA should take steps now to establish

1 both access to patients and appropriate floors for reimbursement which will address these
2 health care models and their potentially deleterious effects on private practice physicians in
3 small and medium-sized groups going forward; and
4

5 Whereas, In the same way as the U.S. Government has protected individuals through the Fair
6 Labor Standards Act of 1938 (29 U.S.C. § 203), which set a minimum wage, and states and
7 municipalities have enacted similar measures, governments have the authority to establish
8 minimum levels of reimbursement for medical practices; therefore be it
9

10 RESOLVED, That our American Medical Association study small medical practices to assess
11 the prevalence of insurance payments to these practices that are below Medicare rates and to
12 assess the effects of these payment levels on practices' ability to provide care, and report back
13 by the 2024 Annual Meeting (Directive to Take Action); and be it further
14

15 RESOLVED, That our AMA study and report back on remedies for such reimbursement rates
16 for physician practices (Directive to Take Action); and be it further
17

18 RESOLVED, That our Council on Medical Service study the impact on small and medium-sized
19 physician practices of being excluded from population health management, outcome evidence-
20 based care, and value-based purchasing arrangements (Directive to Take Action); and be it
21 further
22

23 RESOLVED, That our AMA study and report back to the HOD options for model legislation for
24 states and municipalities seeking to correct reimbursement rates for medical practices that are
25 below those required to meet fixed costs. (Directive to Take Action)

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

Received: 4/27/23

REFERENCES

1. Janower ML. The Resource-Based Relative Value Scale. JAMA. 1988 Mar 4;259(9):1329. PMID: 3339834.
2. Physicians Advocacy Institute. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020. Available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PA-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d

RELEVANT AMA POLICY

Insurance Industry Behaviors D-385.949

Our AMA will: (1) step up its ongoing review of the proper use of the AMA CPT Codes in medical billing claims payments and its misuse by the US Health Insurance Industry; (2) undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry, including a search for potential litigation partners across the medical federation; and (3) communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry.

Citation: Res. 614, I-21; Reaffirmation: A-22;

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-

existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17;

Consultation Codes and Private Payers D-385.955

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.

2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

Citation: Res. 819, I-17; Reaffirmed in lieu of: Res. 808, I-22;

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990

Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

Citation: Res. 137, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 103, A-13; Reaffirmation: A-19;

National Mandatory Fee Schedule H-385.986

The AMA opposes any type of national mandatory fee schedule.

Citation: (Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation A-15)

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923

1. Our AMA adopts as policy the following definitions:

(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);

(b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and

(c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: (Res. 109, A-07; Appended: Res. 107, A-13)

Physician Choice of Practice H-385.926

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93;

Reaffirmed: Sub. Res. 701, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107, I-93; Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmation I-98; Reaffirmation A-99; Appended by Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; Reaffirmation A-00; Reaffirmation A-00; Sub. Res. 116, I-00; Reaffirmation & Reaffirmed: Res. 217, A-01; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21; Reaffirmed: CMS Rep. 2, A-22;

Payment for Physicians Services H-385.989

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.

Citation: (CMS Rep. A, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmation I-13; Reaffirmation A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Access to Care For Patients in Custody of Protective Services

Referred to: Reference Committee A

- 1 Whereas, In 2020 over 600,000 children were confirmed victims of child abuse of varying types
2 including physical, sexual, neglect, and medical neglect; and
3
- 4 Whereas, In 2020 over 600,000 children were placed into the child protective system; and
5
- 6 Whereas, There were over 1.3 million reports of adult abuse and neglect in 2020; and
7
- 8 Whereas, In most instances children placed into the custody of child protective services are also
9 entered into the Medicaid program for health insurance coverage; and
10
- 11 Whereas, In the majority of states Medicaid payment to physicians is less than that of Medicare
12 payment to physicians; and
13
- 14 Whereas, Children and adults placed into protective services often have complex medical and
15 mental health conditions in addition to the risk of removal from their homes; and
16
- 17 Whereas, Many state protective services require physician visits within a limited number of days
18 of placement to ensure the safety of the protectee; and
19
- 20 Whereas, The American Academy of Pediatrics recent report on children removed from family
21 care delineates the best care for children within the protective services system as including
22 three medical visits within the first three months of placement as a best practice for these
23 complicated patients; and
24
- 25 Whereas, Low Medicaid payment rates are a significant barrier to healthcare often preventing
26 these severely at risk children and adults from receiving timely appropriate care within a medical
27 home; and
28
- 29 Whereas, The amount of work physicians perform when caring for patients under the custody of
30 protective services far outweighs work performed on patients not within this system; and
31
- 32 Whereas, Increased private insurance and Medicaid payment rates for patients placed within
33 the protective services system, such as enhanced Federal Medical Assistance Percentage
34 (FMAP), modifiers to signify additional work required and other mechanisms, would improve
35 access to timely appropriate care for these at-risk patients; therefore be it
36
- 37 RESOLVED, That our American Medical Association study and report back mechanisms to
38 improve payment for physician services provided to patients under protective services custody.
39 (Directive to Take Action)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-23)

Introduced by: Mississippi

Subject: Long-Term Care Coverage for Dementia Patients

Referred to: Reference Committee A

1 Whereas, More than 6 million patients are living with Alzheimer’s disease and by 2050 the
2 number will rise to nearly 13 million; and
3
4 Whereas, 1 in 3 seniors die with Alzheimer’s or other dementias; and
5
6 Whereas, In 2023 Alzheimer’s disease and other dementias will cost the US \$345 billion and by
7 2050 nearly \$1 trillion; and
8
9 Whereas, Over 11 million Americans provide unpaid care for patients with Alzheimer’s disease
10 and other dementias; and
11
12 Whereas, In 2022 unpaid caregivers provided approximately 18 billion hours of care valued at
13 almost \$340 billion; and
14
15 Whereas, 6.7 million Americans age 65 or older are living with Alzheimer’s disease. 73% of
16 them are 75 or older; and
17
18 Whereas, 1 in 9 of the population (10.7%) age 65 and older have Alzheimer’s disease; and
19
20 Whereas, Almost 2/3 of Americans with Alzheimer’s disease are women; and
21
22 Whereas, Between 2020 to 2030 an additional 1.2 million direct care workers will be needed to
23 care for the growing dementia population which is the largest worker gap in the United States;
24 and
25
26 Whereas, Long-term care is a range of services and support for personal care needs; and
27
28 Whereas, Medicare and most health insurance plans including Medicare supplement insurance
29 (Medigap) do not pay for long-term care; and
30
31 Whereas, Private insurance plans covering long-term care are scarce and very expensive; and
32
33 Whereas, Long-term Medicaid is the only plan The Centers for Medicare and Medicaid Services
34 provide for long-term care; and
35
36 Whereas, To qualify for long-term Medicaid patients have to satisfy draconian financial
37 guidelines; therefore be it

- 1 RESOLVED, That our American Medical Association work with Centers for Medicare &
- 2 Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance
- 3 plans to cover this ever-growing disenfranchised population. (Directive to Take Action)

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

Received: 5/2/23

Reference Committee B

BOT Report(s)

- 09 Council on Legislation Sunset Review of 2013 House Policies
- 11 HPSA and MUA Designation For SNFs
- 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners

Resolution(s)

- 201 Pharmacists Prescribing for Urinary Tract Infections
- 202 Support for Mental Health Courts
- 203 Drug Policy Reform
- 204 Supporting Harm Reduction
- 205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness
- 206 Tribal Public Health Authority
- 207 Ground Ambulance Services and Surprise Billing
- 208 Medicaid Managed Care for Indian Health Care Providers
- 209 Purchased and Referred Care Expansion
- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border
- 211 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits
- 212 Marijuana Product Safety
- 213 Telemedicine Services and Health Equity
- 214 Advocacy and Action for a Sustainable Medical Care System
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud
- 216 Improved Foster Care Services for Children
- 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
- 218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
- 219 Repealing the Ban on Physician-Owned Hospitals
- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
- 223 Protecting Access to Gender Affirming Care
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-23

Subject: Council on Legislation Sunset Review of 2013 House Policies

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
- 6 1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain
8 it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
 - 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the HOD identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way
21 for the HOD to handle the sunset reports.
22
 - 23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
25 policy, or has been accomplished.
26
 - 27 4. The AMA councils and the HOD should conform to the following guidelines for sunset:
28 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD
31 Reference Manual: Procedures, Policies and Practices.
32
 - 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
 - 35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.970	Drug Enforcement Administration Licensure Fees	Our AMA will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians. (Res. 219, I-13)	Retain – this policy remains relevant.
D-120.948	FDA Recommendation on Scheduling of Hydrocodone Combination Products	Our AMA will issue a public statement to the US Food and Drug Administration urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act. (Res. 518, A-13)	Sunset this policy. This policy has been completed. See: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffda-rescheduling-letter-22march2013.pdf and https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf
D-145.997	Physicians and the Public Health Issues of Gun Safety	Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths. (Res. 410, A-13)	Sunset this policy. The Surgeon General issued a report on suicide in 2021, “ The Surgeon General’s Call to Action to Implement the National Strategy for Suicide Prevention. ” There have been more recent calls on the Surgeon General to develop a report on reducing firearm-related injuries and deaths and our AMA

Policy Number	Title	Text	Recommendation
			has more recent policies supporting government funding for research into preventing firearm injuries and deaths (Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975)
D-150.976	Hazards of Energy Beverages - Their Abuse and Regulation	<p>1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).</p> <p>2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.</p> <p>3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.</p> <p>(Res. 909, I-11; Appended: Res. 409, A-13)</p>	Retain – this policy remains relevant.
D-175.986	Physician Prosecution	<p>Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues.</p> <p>(Res. 212, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
D-190.973	The SAFE Act	<p>Our AMA will seek immediately an opinion and guidance from Health and Human Services Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the State SAFE Act and federal HIPAA regulations.</p> <p>(Res. 228, A-13)</p>	<p>Sunset this policy.</p> <p>Clarification regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in compliance with standards set forth by the State SAFE Act and with federal HIPAA regulations is provided by the New York State Office</p>

Policy Number	Title	Text	Recommendation
			<p>of NICS Appeals & SAFE Act, set forth in FAQs and guidance documents available at: https://nics.ny.gov/safe-act.html</p> <p>Among the above-referenced FAQs is the following information:</p> <p>Q: Are such reports in compliance with HIPAA?</p> <p>A: Under HIPAA, because these informational disclosures are required by law, they can be made without the patient's consent. HIPAA permits disclosures of protected health information without the authorization or consent of the individual to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law.</p>
D-190.982	HIPAA Extension	<p>Our AMA will: (1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and (2) take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper.</p> <p>(Res. 224, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). It is no longer relevant as the transition period following October 16, 2003, when the HIPAA transaction rule took effect, has passed.</p>
D-190.983	Protection of Health Care Providers from Unintended Legal	<p>Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
	Consequences of HIPAA	<p>Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.</p> <p>(Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
D-330.913	Direct-to-Consumer Advertising of Durable Medical Equipment and Medical Supplies	<p>1. Our AMA will pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment (DME) and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), “Dear Physician Letter” from DME Contractor Medical Directors, Local Coverage Determination or associated policy article; and (c) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.</p> <p>2. Our AMA recommends that DME companies stop coercive acts which inappropriately influence physicians to sign these prescriptions for their patients.</p> <p>(BOT Rep. 14, A-13)</p>	<p>Sunset this policy.</p> <p>Our AMA has responded to opportunities to testify on direct-to-consumer (DTC) issues that affect the membership. While this reference is to “examining the drug supply chain,” the effect of DTC on the patient-physician is on the record. See: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-1-23-Dr-Harmon-Response-to-Pharmaceutical-Distribution-Chain.pdf.</p> <p>In addition, other AMA policy reaffirmed at the I-22 HOD Meeting covers many of the nuances on this issue: See: Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988.</p>

Policy Number	Title	Text	Recommendation
D-35.984	Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy	<p>1. Our AMA will (a) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (b) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.</p> <p>2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.</p> <p>(BOT Rep. 10, I-11; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.990	Limiting the Scope of Practice of Specialist Assistants in Radiology	<p>Our AMA supports the efforts of the American College of Radiology and will work with the Scope of Practice Partnership and interested Federation partners to obtain regulation or legislation which would preclude a Specialist Assistant in Radiology or other non-physician practitioner from rendering an official report of any image produced by any diagnostic imaging technique.</p> <p>(Res. 219, A-06; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.996	Scope of Practice Model Legislation	<p>Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation</p>	<p>Sunset this policy.</p> <p>This policy has been accomplished. Model legislation has been approved by the Council on Legislation and Board of Trustees and distributed to state and specialty medical societies. Our AMA continues to work</p>

Policy Number	Title	Text	Recommendation
		<p>as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.</p> <p>(Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>with state and specialty medical societies on this legislation as part of our extensive scope of practice advocacy activities and policy.</p>
D-360.993	Recognition of the "Nurse as Agent" of the Prescriber in Long Term Care Settings	<p>Our AMA will urge the US Drug Enforcement Administration to amend its regulations to recognize nursing staff as agents of the prescriber/physician in long term care facilities.</p> <p>(Res. 222, A-09; Reaffirmation A-13)</p>	<p>Sunset this policy.</p> <p>This has been accomplished. See: https://fnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber.</p>
D-390.955	Flexibility in Medicare Opt-Out and New Safe Harbor	<p>1. Our AMA will seek regulation or legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out.</p> <p>2. Our AMA will seek legislation and work with the Centers for Medicare & Medicaid Services, as appropriate, to allow for a safe-harbor period for a physician to continue to remain opted out of the Medicare program, without penalty or possibility of recoupment, in those circumstances where the physician has mistakenly not been reaffirming an intention to be opted out.</p> <p>(Res. 234, A-13)</p>	<p>Retain – this policy remains relevant.</p>
D-390.971	Medicare Reimbursement for Anesthesiologists	<p>Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians.</p> <p>(BOT Action in response to referred for decision Res. 718, I-05; Reaffirmed in lieu of Res. 207, A-13)</p>	<p>Sunset this policy.</p> <p>The sustainable growth rate (SGR) payment formula was replaced by the Medicare Access and CHIP Reauthorization Act of 2015, which repealed the SGR formula and put in place a new payment system for physicians participating in Medicare.</p>
D-40.993	Inequity in Military Pay for Physicians	<p>Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>bill based on H.R. 5353 (107th Congress) in this Congress.</p> <p>(BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
D-435.988	Family Protection Act	<p>Our AMA will develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform.</p> <p>(BOT Rep. 9, I-03; Modified: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
D-478.981	Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities	<p>Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.</p> <p>(Res. 827, I-10; Reaffirmation I-13)</p>	<p>Sunset this policy.</p> <p>There has been on-going work in this area across the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, Office of national Coordinator, Office of Civil Rights, among other federal agencies and research entities. Our AMA consistently comments on this matter as regulations propose changes to HIT standards, existing rules relating to privacy, and interoperability of protected health information.</p> <p>In addition, our AMA has other policy on point: EHR Interoperability D-478.972, Health Information Technology D-478.994, Information Technology Standards and Costs D-478.996, National Health Information Technology D-478.995</p>
H-100.979	Repeal of Federal Regulations	The AMA urges the Drug Enforcement Administration to develop an alternative system for identifying partially filled	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>prescriptions for Schedule II drugs that does not reveal diagnostic information.</p> <p>(Sub. Res. 511, A-92; Reaffirmed: BOT Rep. 28, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-120.969	Dispensing Controlled Substances to Long Term Care Patients	<p>The AMA will work with the Drug Enforcement Administration to amend the Code of Federal Regulations to allow for pharmacy service providers to use appropriately authenticated medication orders from patients' charts in place of an original prescription for controlled substances for long term care patients.</p> <p>(Res. 204, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: Res. 209, A-11; Reaffirmation A-13)</p>	Retain – this policy remains relevant.
H-15.961	Safety for Passengers in the Back of Pickup Trucks	<p>The AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.</p> <p>(Res. 409, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-15.966	Preventing Underride Motor Vehicle Crash Injury	<p>The AMA supports a federal action, regulatory or legislative as appropriate, that would require rear and side impact guards on all new tractor trailers.</p> <p>(Res. 426, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-150.932	Reform the US Farm Bill to Improve US Public Health and Food Sustainability	<p>Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.</p> <p>(Res. 215, A-13)</p>	Retain – this policy remains relevant.
H-160.931	Health Literacy	<p>Our AMA:</p> <p>(1) recognizes that limited patient literacy is a barrier to effective medical</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>diagnosis and treatment;</p> <p>(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;</p> <p>(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;</p> <p>(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;</p> <p>(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;</p> <p>(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;</p> <p>(7) encourages the allocation of federal and private funds for research on health literacy;</p> <p>(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;</p> <p>(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and</p> <p>(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.</p>	

Policy Number	Title	Text	Recommendation
		(CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13)	
H-160.950	Guidelines for Integrated Practice of Physician and Nurse Practitioner	<p>Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:</p> <ol style="list-style-type: none"> (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings. (2) The physician is responsible for managing the health care of patients in all practice settings. (3) Health care services delivered in an integrated practice must be within the scope of each practitioner’s professional license, as defined by state law. (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients. (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients’ condition, as determined by the supervising/collaborating physician. (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts. (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients’ condition. (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. 	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.</p> <p>(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.</p> <p>(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.</p> <p>(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-180.970	Expanded State/Federal Regulation Oversight of Multiple Employer Welfare Arrangements	<p>The AMA supports appropriate federal and state initiatives to regulate and oversee health care plans provided through multiple employer welfare arrangements.</p> <p>(Sub. Res. 204, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-180.998	Regulation of Insurance Carriers and Health Plans	<p>Our AMA believes that organizations financing health care services (e.g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of costs or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards.</p> <p>(BOT Rep. A, NCCMC Rec. 7, A-78; Reaffirmed: CLRPD Rep. C, A-89;</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)	
H-190.969	Delay in Payments Due to Disputes in Coordination of Benefits	<p>Our AMA:</p> <p>(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;</p> <p>(2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;</p> <p>(3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;</p> <p>(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;</p> <p>(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;</p> <p>(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.</p> <p>(CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)</p>	
H-260.973	Cost and Benefits of CLIA '88 and Other Health Regulations	<p>The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary, and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care.</p> <p>(Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.975	Repeal of CLIA	<p>The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88.</p> <p>(Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.977	Commission on Office Laboratory Accreditation	<p>The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the “deeming” regulations under CLIA '88;</p> <p>(2) take immediate action to assure that applications for deemed status under</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible;</p> <p>(3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and</p> <p>(4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification.</p> <p>(Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-270.954	Regulatory Modernization	<p>Our AMA will work with regulatory bodies at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice.</p> <p>(Res. 225, A-13)</p>	Retain – this policy remains relevant.
H-270.955	Allow Physicians to Receive Dual Use Supplies for In-Office Blood Collection	<p>Our AMA supports legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month.</p> <p>(Res. 208, A-13)</p>	Retain – this policy remains relevant.
H-270.974	Acupuncture	<p>It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine.</p> <p>(CME Rep. M, A-93; Modified: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	Retain – this policy remains relevant.
H-270.977	FDA Intrusion into the Practice of Medicine	<p>The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>written without the input of specialists in the related field of medicine.</p> <p>(Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	
H-285.985	Discrimination Against Physicians by Health Care Plans	<p>Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;</p> <p>(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;</p> <p>(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;</p> <p>(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and</p> <p>(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)	
H-290.988	Monitoring of State Medicaid DUR Programs	<p>The AMA will continue to monitor the progress, quality and problems associated with the Omnibus Budget Reconciliation Act of 1990 mandated state Medicaid Drug Use Review (DUR) programs and assure that DUR programs focus on the quality of patient care and use appropriate scientifically based criteria to evaluate individual patient therapy and the effectiveness of physician and pharmacist activities.</p> <p>(Res. 526, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	<p>Sunset this policy.</p> <p>Our AMA has adopted broader Drug Use Review policy. See: Principles of Drug Utilization Review H-120.978 and Drug Utilization Review H-120.981.</p>
H-30.951	Boating Under the Influence	<p>It is the policy of the AMA to support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.</p> <p>(Res. 405, I-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-315.989	Confidentiality of Computerized Patient Records	<p>The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.</p> <p>(BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 17, A-13)</p>	<p>Sunset this policy.</p> <p>This policy has been superseded by more recent policy. See: Ransomware and Electronic Health Records D-478.960, Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973, Code of Medical Ethics 3.3.2 Confidentiality & Electronic Medical Records.</p>

Policy Number	Title	Text	Recommendation
H-330.887	Submitting Recommendations to Medicare	<p>Our AMA will work with the Centers for Medicare & Medicaid Services and seek federal legislation, if necessary, to provide that the Center for Medicare and Medicaid Innovation Center website accept suggestions from physicians to improve health care and/or reduce costs, acknowledge submission by receipt, and notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and, if the decision is deemed worthy, the submitter should be informed and encouraged to participate in further developing the idea if they wish to remain involved.</p> <p>(Res. 226, A-13)</p>	Retain – this policy remains relevant.
H-330.922	Waiver of Copayments of Certain Medicare Patients	<p>Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance.</p> <p>(Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-330.945	Durable Medical Equipment Requirements	<p>Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of</p>	Retain – this policy remains relevant.

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		<p>practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.</p> <p>(Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04; Reaffirmed: BOT Rep. 14, A-13; Modified in lieu of Res. 802, I-13)</p>	
H-330.951	Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients	<p>The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients.</p> <p>(Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-330.960	Cost of Medically Related Services and Supplies	<p>The AMA legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form.</p> <p>(Res. 812, A-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: BOT Rep. 14, A-13)</p>	Retain – this policy remains relevant.
H-330.992	Medicare Definition of Physician	<p>The AMA supports limiting the application of the definition of the term “physician” under the Medicare program to doctors of medicine or osteopathy.</p> <p>(Sub. Res. 101, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: Res. 821, I-09; Reaffirmation A-13)</p>	Retain – this policy remains relevant.
H-350.976	Improving Health Care of American Indians	<p>Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal</p>	Retain – this policy remains relevant.

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		<p>rights and privileges as other U.S. citizens.</p> <p>(2) The federal government provide sufficient funds to support needed health services for American Indians.</p> <p>(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.</p> <p>(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.</p> <p>(5) Our AMA recognize the “medicine man” as an integral and culturally necessary individual in delivering health care to American Indians.</p> <p>(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.</p> <p>(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.</p> <p>(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.</p> <p>(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.</p> <p>(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.</p> <p>(11) Our AMA strongly supports those</p>	

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		<p>bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-350.977	Indian Health Service	<p>The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) <u>Indian Population</u>: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.</p> <p>(2) <u>Federal Facilities</u>: Based on the distribution of the eligible population, transportation facilities and roads, and</p>	Retain – this policy remains relevant.

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		<p>the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.</p> <p>(3) <u>Manpower</u>: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.</p> <p>(4) <u>Medical Societies</u>: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided</p>	

Policy Number	Title	Text	Recommendation
		<p>under their direction, including professional consultation and involvement in society activities should be pursued.</p> <p>(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-355.989	Access to National Practitioner Data Bank “Self-Query” Reports	<p>(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB. (21) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (32) The AMA will provide model language until such legislation is enacted that physicians can use to protect</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). The National Practitioner Data Bank Guidebook specifies that information reported to the NPDB is confidential and cannot be disclosed except as specified in the NPDB statutes and that the Office of the Inspector General can impose civil money penalties on those who violate the confidentiality provisions.</p>

Policy Number	Title	Text	Recommendation
		<p>confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities.</p> <p>(BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	
H-355.990	National Practitioner Data Bank	<p>(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) and allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3)</p>	<p>Retain this policy in part.</p> <p>Delete clauses (2)(a)(b)(c)(f) and clause (3), which are no longer relevant. Regarding clause (3), Policy H-355.991 was rescinded in 2014.</p>

Policy Number	Title	Text	Recommendation
		<p>The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.</p> <p>(BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	
H-360.983	Registered Nurse Participation in Epidural Analgesia	<p>Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions.</p> <p>(Res. 530, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	Retain – this policy remains relevant.
H-360.987	Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice	<p>Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.</p> <p>(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.</p> <p>(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.</p> <p>(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.</p> <p>(5) Physicians should encourage state</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.</p> <p>(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.</p> <p>(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-360.988	Nurse Practitioner Reimbursement Under Medicare	<p>Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician’s supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.</p> <p>(BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed in lieu of Res. 207, A-13)	
H-365.983	Occupational Safety and Health Administration Regulations	<p>The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.</p> <p>(Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-370.962	Equal Access to Organ Transplantation for Medicaid Beneficiaries	<p>Our AMA supports federal funding of organ transplants for Medicaid patients.</p> <p>(BOT Rep. 15, A-13)</p>	Retain – this policy remains relevant.
H-375.995	Implementation of Voluntary Medical Peer Review	<p>The AMA: (1) reaffirms its policy that “peer review should be assigned the highest priority by state and county medical societies; that where these mechanisms exist, they should be strengthened, and where they do not exist they should be promptly established;” (2) recognizes the propriety of peer review organizations contracting with public as well as private organizations for financing of their review services, so long as professional direction and control are maintained; and (3) supports the development of public information programs to inform consumers about existing and newly developed quality assurance activities.</p> <p>(CMS Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-390.885	Advance Payments During Medicare Slow-Downs	<p>The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments.</p> <p>(Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-400.973	Limited Licensed Practitioners and RBRVS	<p>It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services.</p> <p>(Sub. Res. 124, I-91; Reaffirmed: BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03; Modified: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-405.992	“Doctor” as a Title	<p>The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title “Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.</p> <p>(Res. 138, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: Res. 218, A-12)</p>	Retain – this policy remains relevant.
H-410.950	Pain Management	<p>Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:</p> <p>Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>complications, and collaboration with other health care providers.</p> <p>Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:</p> <ol style="list-style-type: none"> 1. ablation of targeted nerves; 2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and 3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators. <p>At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.</p> <p>When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be</p>	

Policy Number	Title	Text	Recommendation
		<p>performed only by physicians with appropriate training and credentialing.</p> <p>Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.</p> <p>(BOT Rep. 16, A-13)</p>	
H-410.951	Physician Practice Drift	<p>Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.</p> <p>(BOT Rep. 5, A-13)</p>	Retain – this policy remains relevant.
H-410.958	Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers	<p>Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>schools in order to demonstrate adherence to current standards in pain management.</p> <p>(Res. 903, I-07; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-425.970	Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities	<p>Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.</p> <p>(Res. 911, I-13)</p>	Retain – this policy remains relevant.
H-435.964	Federal Preemption of State Professional Liability Laws	<p>The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.</p> <p>(Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-435.965	“Clear and Convincing” Standard of Proof in Medical Liability Cases	<p>1. The AMA continues to support the use of the clear and convincing evidence standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent non-meritorious claims from being filed or to quickly resolve them before extensive litigation proceeds.</p> <p>2. Our AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard.</p> <p>(BOT Rep. 51, A-94; Reaffirmed: BOT Rep. 12, A-05; Appended: BOT Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-435.966	Prohibit Third Party Payers from Requiring	<p>The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Professional Liability Coverage Beyond Mandated Limits	<p>professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law.</p> <p>(Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-435.998	Equitable Risk Classification in Medical Liability Premiums	<p>Our AMA supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums.</p> <p>(Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-440.926	United States Surgeon General	<p>The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis.</p> <p>(Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-475.986	Surgical Assistants other than Licensed Physicians	<p>Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures; (2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical</p>	<p>Retain this policy in part.</p> <p>Delete the reference to the American College of Surgeons’ (ACS) Statements on Principles. ACS has changed their</p>

Policy Number	Title	Text	Recommendation
		<p>assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;</p> <p>(3) policy related to surgical assistants consistent with the American College of Surgeons' Statements on Principles states: (a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure.</p> <p>(b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon.</p> <p>(c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage</p>	<p>policy related to surgical assistants.</p>

Policy Number	Title	Text	Recommendation
		<p>and current competence.</p> <p>(d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.</p> <p>(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons.</p> <p>(BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-475.989	Laser Surgery	<p>Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy.</p> <p>(Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-480.947	Medical Patents and Their Infringement on the Art of Medicine	<p>Our AMA supports for the Ganske Compromise and discourages the medical community from soliciting patents on medical methodology.</p> <p>(BOT Action in response to referred for decision Res. 223, A-03; Modified: CSAPH Rep. 1, A-13)</p>	<p>Sunset this policy.</p> <p>AMA Code of Medical Ethics 7.2.3 Patents & Dissemination of Research Products, modified in 2017, captures the intent of this older policy.</p>
H-520.986	The Future of Genito-Urinary Treatment and Research	<p>1. Our AMA supports legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and mental health care.</p> <p>2. Our AMA, in consultation with relevant medical specialty societies, will promote the study of genito-urinary trauma in members of the Armed Forces and Veterans to improve the diagnosis, prevention and treatment of genito-urinary injuries.</p> <p>(Res. 227, A-13)</p>	<p>Retain – this policy remains relevant.</p>
H-60.959	Uniformity of State Adoption and Child Custody Laws	<p>The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the “best interest of the child” as the most important criterion determining custody, placement, and adoption of children.</p> <p>(Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>Sunset this policy.</p> <p>The Uniform Adoption Act was retired as an act of the Uniform Law Commission (ULC, previously known as the National Conference of Commissioners on Uniform State Laws) in July 2017. According to ULC meeting minutes, the ULC discontinued the uniform act because it had only been adopted by one state and contained outdated provisions.</p>
H-60.969	Childhood Immunizations	<p>1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.</p> <p>2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.</p> <p>3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.</p> <p>4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.</p> <p>5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.</p> <p>6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.</p> <p>(Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13)</p>	
H-70.939	Definition of Consultation: CMS vs. CPT 4 Coding Manual	<p>(1) Our AMA and the Federation make known to CMS that redefining consultation to achieve cost savings is unacceptable to the medical profession.</p> <p>(2) That if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>part of CMS. (3) Our AMA urges the CPT Editorial Panel to review the CPT definitions for consultations and make any needed clarifications.</p> <p>(Res. 822, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12)</p>	

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-23

Subject: HPSA and MUA Designation For SNFs
(Resolution 224-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

1 At the June 2022 Annual Meeting, the House of Delegates referred Resolution 224-A-22, “HPSA
2 and MUA Designation for SNFs,” sponsored by the Society for Post-Acute and Long-Term Care
3 Medicine (AMDA). Resolution 224-A-22 asked the American Medical Association (AMA) to
4 advocate for legislative action directing the U.S. Department of Health and Human Services (HHS)
5 to “designate all skilled nursing facilities (SNFs), irrespective of their geographic location, as
6 health professional shortage areas (HPSAs) and/or medically underserved areas (MUAs) to
7 facilitate recruitment and retention of health professionals using the usual and customary support
8 made available for such designations.”
9

10 Testimony regarding this resolution was generally positive, highlighting the benefits of HPSA and
11 MUA designations to areas in need of additional health care resources. Testimony indicated that,
12 due to a rapidly aging population (along with the lack of commensurate increases in medical school
13 and residency positions, early retirement of health care professionals from burnout and the
14 pandemic, and a lack of direct incentives to practice in senior living communities), there is an acute
15 shortage of health care professionals, including physicians, nurses, and clinical practitioners in
16 nursing facilities. Testimony also indicated that the AMA has ample policy that supports legislation
17 to address the need to enhance resources for physicians practicing in rural counties and other areas
18 where the poverty rate exceeds a certain threshold. In addition, testimony stated that AMA policy
19 includes clear instruction for the AMA to support legislation and encourage federal and state
20 governments to provide financial assistance to assist physician practices in shortage areas. Due to
21 the mixed testimony provided, Resolution 224-A-22 was referred. This report focuses on physician
22 shortages in the U.S. and the need to incentivize physicians to practice in nursing facilities and to
23 facilitate recruitment and retention of health professionals in these settings.
24

25 **BACKGROUND**
26

27 Physician shortage is a significant issue in the U.S. To address this issue, the federal government
28 developed HPSA and MUA designations used to identify areas and population groups that
29 experience physician shortages and to improve access to health care for patients in these areas. It is
30 projected that by 2032 there will be a 50 percent growth in the population of those aged 65 and
31 older, compared with only a 3.5 percent growth for those aged 18 or younger.¹ By 2033 it is
32 estimated that there will be a shortage of between 54,100 and 139,000 physicians, which includes a
33 projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of
34 non-primary care specialty physicians of between 33,700 and 86,700.² Furthermore, the COVID-19
35 pandemic put an incredible strain on our health care system and drastically exacerbated physician
36 shortages in many rural and underserved areas across the country, which forced states to take

1 extraordinary measures such as recalling retired physicians, expanding scope of practice, and
2 temporarily amending out of state licensing laws.³ However, none of these adjustments are
3 expected to permanently fill the physician shortage gap in the long term.

4 5 HEALTH PROFESSIONAL SHORTAGE AREAS AND MEDICALLY UNDERSERVED 6 AREAS

7
8 HPSAs are intended to improve access to health care in areas, population groups, or facilities
9 within the U.S. that experience physician shortages. This designation allows physicians to gain
10 eligibility for financial incentives, such as loan repayment and scholarships, that can help attract
11 and retain physicians in rural and underserved areas, which typically experience physician
12 shortages. However, according to a report by the Government Accountability Office (GAO), only
13 about one-third of primary care shortage areas were designated as HPSAs as of 2019.⁴

14
15 MUAs, like HPSAs, allow physicians to be eligible for financial incentives, such as loan repayment
16 and scholarships, to help attract and retain physicians in shortage areas. In addition, MUAs can
17 increase the availability of primary care services in areas with high poverty rates. Similar to
18 HPSAs, MUAs may not cover all shortage areas and the financial incentives may not be enough to
19 attract and retain physicians.

20 21 ADDITIONAL CONSIDERATIONS

22
23 To provide financial incentives for physicians who work in shortage areas, several programs have
24 been implemented to address the financial burden of medical education, which is a major barrier to
25 physicians choosing to work in shortage areas. In addition, the federal government has
26 implemented several programs to incentivize physicians and other health care providers to work in
27 underserved areas and with underserved populations.

28 29 *Incentivizing Physicians and Medical Students*

30
31 The National Health Service Corps (NHSC) is a federal program that provides scholarships to
32 medical students starting at the beginning of medical school, and loan repayment post completion
33 of residency training in a primary care specialty, for a minimum of two years commitment work in
34 HPSAs throughout the United States and United States territories. The NHSC also has scholarship
35 and loan repayment programs for dentists, nurse practitioners, nurse midwives, and physician
36 assistants.⁵ In addition to the NHSC, the Indian Health Service (IHS) is a federal program that
37 provides loan repayment and housing assistance to physicians and other health care providers who
38 work in Indian Health Service facilities. The IHS is intended to improve the health status of
39 American Indian and Alaska Native people by increasing access to health care services.⁶

40
41 To incentivize medical students, some medical schools offer scholarships to students who commit
42 to working in underserved areas after graduation. For example, the University of Washington
43 School of Medicine offers the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho)
44 program, which provides scholarships to medical students who commit to certain states that
45 experience physician shortages after graduation.⁷ In addition, medical schools may partner with
46 health care facilities in underserved areas to provide clinical experiences for students, which can
47 help attract and retain health care professionals.

1 J-1 AND H-1B VISAS

2
3 As a strategy to help provide additional physicians, international medical graduates (IMGs) often
4 work in rural and underserved areas.⁸ In 2017, nearly 30 percent of medical residents were IMGs,
5 with about half working as physicians on non-immigrant visas.⁹ The AMA recognizes that it is
6 important to support and create pathways for these physicians to be able to remain in the U.S. and
7 care for their patients.

8
9 J-1 visas attract foreign medical graduates with the needed expertise to work in nursing facilities
10 and assisted living facilities where they can help improve the quality of care for patients. By
11 expanding the J-1 visa program to include geriatrics and post-acute and long-term care as
12 designated areas of need, the U.S. can attract more qualified physicians to work in these care
13 settings keeping in mind that J-1 visa programs must have language requirements to ensure that
14 clinicians have a sufficient level of proficiency in English to communicate effectively with patients
15 and other health care workers.

16
17 H-1B visas are a type of temporary work visa that allow foreign workers to enter and work in the
18 U.S. in specialty occupations. In health care, this can include physicians who have completed their
19 medical training outside the U.S. and want to practice in the U.S. H-1B visa programs can be
20 effective in addressing the shortage of qualified clinicians in nursing facilities and assisted living,
21 particularly in underserved areas.

22
23 LOAN FORGIVENESS INCENTIVES

24
25 Loan forgiveness programs can be an effective way to incentivize clinicians to work in nursing
26 facilities. These programs provide financial assistance to clinicians in exchange for a commitment
27 to work in an underserved area. By providing financial incentives, loan forgiveness programs can
28 help address physician shortages in nursing and assisted living facilities.

29
30 AMA POLICY

31
32 AMA policy supports legislation to extend the 10 percent Medicare payment bonus to physicians
33 practicing in rural counties and other areas where the poverty rate exceeds a certain threshold,
34 regardless of the areas' HPSA status (Policy H-465.981, "Enhancing Rural Physician Practices").
35 The same policy supports legislation that would allow physician practices in shortage areas to
36 qualify as Rural Health Clinics without the need to employ one or more physician extenders and
37 directs the AMA to undertake a study of structural urbanism, federal payment policies, and the
38 impact on rural workforce disparities. This policy recognizes that many rural and low-income areas
39 may have difficulty attracting and retaining physicians with specialized training, including
40 geriatricians, and seeks to address this issue through targeted financial and non-incentives.
41 Additionally, Policy H-200.972, "Primary Care Physicians in Underserved Areas", provides a plan
42 for the AMA to improve the recruitment and retention of physicians in underserved areas with
43 underserved populations and can also help to address the shortage of physicians, including those
44 with geriatrics training, in these areas.

45
46 AMA policy also supports efforts to quantify the geographic maldistribution and physician
47 shortage in many specialties and encourages medical schools and residency programs to consider
48 developing admissions policies, practices, and targeted educational efforts aimed at attracting
49 physicians to practice in shortage areas and to provide care to underserved populations; encourages
50 medical schools and residency programs to continue to provide courses, clerkships, and
51 longitudinal experiences in rural and other shortage areas as a means to support educational

1 program objectives and to influence the choice of graduates' practice locations; and encourages
2 medical schools to include criteria and processes in the admission of medical students that are
3 predictive of graduates' eventual practice in shortage areas and with underserved populations
4 (Policy H-200.954, "US Physician Shortage.")

5
6 AMA policy also supports full appropriation for the NHSC Scholarship Program, with the
7 provision that medical schools serving states with large rural and underserved populations have a
8 priority and significant voice in the selection of recipients for those scholarships (Policy H-
9 465.988, "Educational Strategies for Meeting Rural Health Physician Shortage.")

10 DISCUSSION

11
12 The shortage of physicians and other qualified clinicians in skilled nursing facilities and assisted
13 living facilities is a growing problem that has a significant impact on patient care. Patients in these
14 settings often have complex medical needs and require specialized care from physicians with
15 expertise in geriatrics and post-acute and long-term care (PALTC). Increasing the supply of
16 qualified physicians (e.g. geriatricians) to SNFs will help to improve the quality of care provided,
17 decrease medical errors, and improve outcomes as the need for physicians with additional training
18 in geriatrics and PALTC continues to grow as the population ages.

19
20 Further, improving care in underserved areas and populations is a critical issue in our country.
21 However, designating all SNFs, irrespective of their geographic location, as a HPSA or MUA
22 would be a fundamental shift away from viewing geographic areas and populations as a
23 designation criteria to looking at a specific type of facility, including facilities that may be located
24 outside a HPSA/MUA or facilities that are not financially disadvantaged. Also, the goal of the
25 resolution looks beyond facilitating the recruitment and retention of physicians to potentially
26 extend the HPSA/MUA incentive to non-physicians. AMA policy supports a physician-led team
27 with regard to mid-level trained health care workers such as nurse practitioners, nurse midwives,
28 and physician assistants.

29
30 Under the current system, HPSA and MUA designations are a valuable tool for identifying areas
31 with a shortage of physicians and other health care providers, which can help allocate resources to
32 improve access to health care services. Rather than designating a specific type of facility, such as
33 SNFs, they provide a broader framework for addressing health care disparities and physician
34 shortage issues. Regarding scope of practice concerns, SNFs often rely on a team-based approach
35 to care, which includes physicians, nurse practitioners, and other health care professionals.
36 However, without a physician leading the care team, there is a risk that the overall quality of care
37 as well as resident training may suffer. Physicians play a critical role in providing guidance and
38 oversight to the care team, ensuring that residents receive appropriate training and education. In
39 this regard, it is important to note that, to the extent that SNF patients are in a HPSA, MUA, or
40 generally in an underserved area, the AMA already has policy¹⁰ in place to incentivize physicians
41 to practice in those areas.

42 43 CONCLUSION

44
45 The Board of Trustees (Board) recognizes that the shortage of physicians in SNFs is a critical issue
46 and shares the goal of ensuring that patients in SNFs receive high-quality care and believes that
47 Resolution 224-A-22 provides another example of how the shortage of physicians is impacting
48 patient access to care, including in SNFs. However, the solution offered in this resolution would
49 fundamentally change how shortage areas and underserved populations are determined and raises
50 scope of practice concerns. As discussed above, the AMA has existing policy that more broadly

1 addresses the physician shortage issue and can be applied in a way to address the shortage of
2 physicians practicing in SNFs. These policies include efforts to quantify geographic
3 maldistribution, encourage medical schools and residency programs to provide courses and
4 experiences in underserved areas, and support the NHSC Scholarship Program. The Board,
5 therefore, recommends reaffirmation of existing policy in lieu of adopting Resolution 224-A-22.
6

7 RECOMMENDATIONS

8

9 The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution
10 224-A-22, and the remainder of the report be filed:
11

- 12 1. That our AMA reaffirm Policy [H-465.981](#), which asks our AMA to:
 - 13 a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural
14 counties and other areas where the poverty rate exceeds a certain threshold, regardless of the
15 areas' Health Professional Shortage Area (HPSA) status;
 - 16 b. encourage federal and state governments to make available low interest loans and other
17 financial assistance to assist physicians with shortage area practices in defraying their costs of
18 compliance with requirements of the Occupational Safety and Health Administration,
19 Americans with Disabilities Act and other national or state regulatory requirements;
 - 20 c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to
21 establish a waiver process through which shortage area practices can seek exemption from
22 specific elements of regulatory requirements when improved access, without significant
23 detriment to quality, will result;
 - 24 d. supports legislation that would allow shortage area physician practices to qualify as Rural
25 Health Clinics without the need to employ one or more physician extenders; and
 - 26 e. undertake a study of structural urbanism, federal payment polices, and the impact on rural
27 workforce disparities. (Reaffirm HOD Policy)
- 28
29 2. That our AMA reaffirm Policy [H-200.972](#), "Primary Care Physicians in Underserved Areas",
30 which provides a plan for the AMA to improve the recruitment and retention of physicians in
31 underserved areas with underserved populations. (Reaffirm HOD Policy)
32
- 33 3. That our AMA reaffirm Policy [H-280.979](#), which asks our AMA to support the following:
 - 34 a. continuing discussion with CMS to improve Medicare reimbursement to physicians for
35 primary care services, specifically including nursing home and home care medical services;
 - 36 b. continued efforts to work with the Federation to educate federal and state legislative bodies
37 about the issues of quality from the perspective of attending physicians and medical directors
38 and express AMA's commitment to quality care in the nursing home;
 - 39 c. efforts to work with legislative and administrative bodies to assure adequate payment for
40 routine visits and visits for acute condition changes including the initial assessment and
41 ongoing monitoring of care until the condition is resolved; and
 - 42 d. assisting attending physicians and medical directors in the development of quality assurance
43 guidelines and methods appropriate to the nursing home setting.
44 (Reaffirm HOD Policy)
- 45
46 4. That our AMA reaffirm Policy [D-200.980](#), which asks our AMA to advocate for the following:
 - 47 a. Continued federal and state support for scholarship and loan repayment programs, including
48 the National Health Service Corps, designed to encourage physician practice in underserved
49 areas and with underserved populations;
 - 50 b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program;

- 1 c. Adequate funding for programs under Title VII of the Health Professions Education
2 Assistance Act that support educational experiences for medical students and resident
3 physicians in underserved areas; and
4 d. Encourages medical schools and their associated teaching hospitals, as well as state medical
5 societies and other private sector groups, to develop or enhance loan repayment or scholarship
6 programs for medical students or physicians who agree to practice in underserved areas or
7 with underserved populations.
8 (Reaffirm HOD Policy)
9
- 10 5. That our AMA reaffirm Policy [H-200.954](#), which encourages medical schools and residency
11 programs to consider developing admissions policies and practices and targeted educational
12 efforts aimed at attracting physicians to practice in underserved areas and to provide care to
13 underserved populations. (Reaffirm HOD Policy)
14
- 15 6. That our AMA reaffirm Policy [H-465.988](#), which provides educational strategies for meeting
16 rural health physician shortages. (Reaffirm HOD Policy)

Fiscal Note: Less than \$5000.

¹ <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.

² AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projectionsjune-2020.pdf>.

³ <https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic>.

⁴ U.S. Government Accountability Office. (2020). Health Professional Shortage Areas: Opportunities Remain to Improve Designation Process. GAO-21-47.

⁵ <https://nhsc.hrsa.gov/>.

⁶ <https://www.ihs.gov/>.

⁷ <https://www.uwmedicine.org/school-of-medicine/md-program/wwami>.

⁸ <https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained-doctors-are-critical-to-serving-many-us-communities.pdf>.

⁹ <https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america>.

¹⁰ AMA Policy [D-200.980](#), Effectiveness of Strategies to Promote Physician Practice in Underserved Areas; [H-200.972](#), Primary Care Physicians in Underserved Areas; [H-200.954](#), US Physician Shortage H-200.954; [H-465.988](#), Educational Strategies for Meeting Rural Health Physician Shortage.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-23

Subject: Promoting Proper Oversight and Reimbursement for Specialty Physician
Extenders and Non-Physician Practitioners
(Resolution 248-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD), referred Resolution 248-A-22 for report at the 2023 Annual Meeting. The resolution was
5 introduced by the Organized Medical Staff Section and asks:

6
7 [That] our AMA work with state medical boards to improve oversight and coordination of the
8 work done with physician extenders and non-physician practitioners (Directive to Take
9 Action); and be it further

10
11 That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each
12 state should have oversight of cases involving specialty care as boards with oversight over
13 physician extenders and non-physician practitioners do not have the training to oversee
14 specialty care (New HOD Policy); and be it further

15
16 That our AMA adopt the position that in each state the Board of Medical Examiners or its
17 equivalent should have oversight over physician extenders and non-physician practitioners if
18 billing independently or in independent practice as their respective oversight boards do not
19 have experience providing accurate oversight for specialty care (New HOD Policy).

20
21 The Reference Committee heard that our AMA has existing policy and model state legislation that
22 addresses physician supervision of non-physicians, state medical board oversight of physician-led
23 teams, and medical board oversight of physician agreements with non-physicians. This policy,
24 H-35.965, "Regulation of Physician Assistants," H-35.989, "Physician Assistants," and H-360.987,
25 "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced
26 Practice Nurses in Integrated Practice," not only addresses the first Resolve, but also the sentiment
27 of the entire resolution. Further, there was overall agreement that the intent of the second Resolve
28 was unclear, yet the Board of Trustees notes that clarification was not provided during testimony.
29 Finally, the HOD generally supported the concept of the third Resolve but agreed it was too broad
30 as written. The Reference Committee, as a result, recommended that an alternative resolution be
31 adopted in lieu of Resolution 248. The alternative resolution, offered by our AMA Council on
32 Legislation, sought to focus the language, achieve the goal of the third Resolve, and add to existing
33 AMA policy. Due to the complexity of the issue, the HOD referred Resolution 248 for a report
34 back at the 2023 Annual Meeting.

1 This report provides background information on the role of health care regulatory boards, including
2 but not limited to state medical boards and boards of nursing. Moreover, this report discusses
3 current state laws allowing for joint oversight of certified nurse practitioners and certified nurse
4 midwives by the state boards of medicine and nursing. This report also includes a summary of
5 AMA policy and model state legislation that supports joint regulatory board oversight of advanced
6 practice registered nurses (APRNs). Finally, this report recommends reaffirmation of existing
7 AMA Policy, H-35.965, "Regulation of Physician Assistants," as well as an amendment to
8 AMA Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care
9 Delivered by Advanced Practice Nurses in Integrated Practice" by addition and deletion.

10 11 BACKGROUND

12 13 *The role of occupational boards*

14
15 The licensing and regulation of health care professionals is within the purview of state occupational
16 and regulatory boards. Health care professional regulatory boards ensure that only individuals
17 meeting the minimal qualifications and competencies can obtain a license to practice in the
18 profession. Typically state legislatures or regulatory boards set forth the standards required to
19 obtain a license, such as graduation from an accredited educational program and the requisite
20 degree, certification, passage of a professional examination, and completion of a background
21 check. These measures are in place to protect the public from unqualified health care professionals
22 through licensure. Regulatory boards also ensure that the health care professionals whom they
23 license practice within the applicable standard(s) of care and the scope of practice of their
24 profession. As such, regulatory boards also have the authority to investigate and discipline their
25 licensees who fail to meet these standards.

26 27 *The role of medical boards*

28
29 The primary role of a state medical board is to protect the health and safety of the public by
30 licensing physicians, investigating complaints, and disciplining physicians based on the state
31 medical practice act. There are currently 71 state and territorial medical boards, including more
32 than 50 allopathic (MD) and composite (MD and DO) medical boards and 14 osteopathic (DO)
33 boards. In addition to licensing physicians, state medical boards also license several non-
34 physicians, such as physician assistants, podiatrists, chiropractors, respiratory therapists,
35 occupational therapists, genetic counselors, radiologist assistants, certified anesthesiologist
36 assistants, naturopaths, and acupuncturists. The types of non-physicians licensed and regulated by
37 state medical boards varies widely by state.

38 39 *Regulatory oversight of non-physicians*

40
41 Non-physicians may be regulated directly by a state medical board, through an advisory committee
42 to a state medical board, or by an entirely separate licensing board. For example, while physician
43 assistants are licensed and regulated by the board of medicine in most states, a few states have a
44 separate physician assistant licensing board, and some states have a physician assistant advisory
45 committee under the board of medicine. Similarly, naturopaths are typically licensed by a separate
46 naturopathic board or the board of medicine in states that license naturopaths. Likewise,
47 acupuncturists may be licensed by the board of medicine or a separate board of acupuncture. In
48 contrast, in most states, psychologists are licensed and regulated by a separate board of psychology,
49 and pharmacists are licensed by the board of pharmacy in each state.

1 In most states, certified nurse practitioners, certified nurse midwives, certified registered nurse
2 anesthetists, and clinical nurse specialists, often referred to collectively as “Advanced Practice
3 Registered Nurses” (APRNs) are licensed and regulated exclusively by the board of nursing. Every
4 state has at least one nursing regulatory board and four states (California, Georgia, Louisiana and
5 West Virginia) have two nursing boards: one that regulates registered nurses and one that regulates
6 licensed practical nurses and vocational nurses. At least one state, Nebraska, has a board for
7 registered nurses and a separate board for APRNs. Certified nurse midwives, a type of APRN, are
8 regulated by the board of nursing in most states. At least one state, however, has a separate
9 midwifery board responsible for regulating certified nurse midwives and certified professional
10 midwives. In other states, certified nurse midwives may be regulated by the board of medicine or
11 public health, often with a midwifery advisory committee or council.
12

13 Similarly, in several states the board of medicine and board of nursing have joint regulation of
14 nurse practitioners and other types of APRNs. For example, in Virginia, nurse practitioners are
15 jointly licensed by the Virginia Boards of Medicine and Nursing. Other states have created a
16 separate joint board for regulatory oversight of nurse practitioners practicing independently. For
17 example, in Arkansas, the Full Independent Credentialing Committee (committee) located in the
18 Department of Health, reviews and approves all applications for nurse practitioners who have met
19 the standards for independent practice and apply for a certificate of full independent practice
20 authority. The committee is comprised of four physicians and four nurse practitioners. In addition
21 to approving or denying all applications, the committee is also responsible for reviewing
22 complaints against nurse practitioners who have a certificate. Finally, in several states, the boards
23 of medicine and nursing have joint oversight of some aspect of advanced practice registered
24 nursing. For example, the Alabama Board of Medical Examiners and Board of Nursing jointly
25 approve collaborative practice agreements between physicians and certified nurse midwives or
26 physicians and certified nurse practitioners.
27

28 EXISTING AMA MODEL STATE LEGISLATION AND POLICY

29 *AMA model state legislation*

30
31
32 The AMA’s “Model Act to Support Physician-Led Team Based Health Care” (Model Act) includes
33 a provision stating that APRNs shall be jointly licensed and regulated by the state board of
34 medicine and board of nursing. The Model Act provides a joint regulatory framework and practice
35 parameters including a requirement that the APRN practice as part of a physician-led patient care
36 team.
37

38 *AMA policy*

39
40 The AMA also has existing Policy H-35.965, “Regulation of Physician Assistants,” that supports
41 the “authority of medical licensing and regulatory boards to regulate the practice of medicine
42 through oversight of physicians, physician assistants and related medical personnel” and “opposes
43 legislative efforts to establish autonomous regulatory boards meant to license, regulate and
44 discipline physician assistants outside of the existing state medical licensing and regulatory bodies’
45 authority and purview.” AMA Policy H-35.989, “Physician Assistants,” indicates that state medical
46 boards shall approve physician assistant applications to practice with a licensed physician or group
47 of physicians and provides parameters for such applications. AMA Policy H-360.987, “Principles
48 Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice
49 Nurses in Integrated Practice,” states in part that “[p]hysicians should encourage state medical and
50 nursing boards to explore the feasibility of working together to coordinate their regulatory
51 initiatives and activities.”

1 DISCUSSION

2
3 Our AMA has existing policy, H-35.965, "Regulation of Physician Assistants," and H-35.989,
4 "Physician Assistants," supporting the licensure and regulatory oversight of physician assistants by
5 state medical boards. These two policies support the current regulatory structure in most states, are
6 aligned with AMA's scope of practice advocacy, and address the sentiment of Resolution 248. Our
7 AMA also has policy encouraging state medical and nursing boards to explore working together to
8 coordinate their regulatory activities, H-360.987, "Principles Guiding AMA Policy Regarding
9 Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice."

10 While this language provides the basis for a joint state medical and nursing board regulatory
11 model, the Board of Trustees believes these policies should be strengthened to affirmatively
12 support joint state medical and nursing board licensing and regulatory oversight of certified nurse
13 practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse
14 specialists, when appropriate. The Board of Trustees believes the proffered amendment provides
15 clarity as to the appropriate role of state medical boards in regulating the practice of APRNs
16 seeking scope expansions.

17
18 As discussed above, there is precedent in state law for joint state medical and nursing board
19 regulatory oversight of APRNs. Moreover, AMA's Model Act also includes language supporting a
20 joint medical and nursing board regulatory structure. The AMA will continue to work with state,
21 specialty and national medical societies interested in pursuing AMA's Model Act.

22
23 RECOMMENDATIONS

24
25 The Board of Trustees recommends that the following recommendations be adopted in lieu of
26 Resolution 248-A-22 and that the remainder of the report be filed.

- 27
28 1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965,
29 "Regulation of Physician Assistants," and H-35.989, "Physician Assistants." (Reaffirm
30 HOD Policy)
31
32 2. That Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of
33 Medical Care Delivered by Advanced Practice Nurses in Integrated Practice" be amended
34 by addition and deletion as follows:

35
36 ~~(5) Physicians should encourage~~ Certified nurse practitioners, certified registered nurse
37 anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and
38 regulated jointly by the state medical and nursing boards ~~explore the feasibility of working~~
39 ~~together to coordinate their regulatory initiatives and activities.~~ (Modify Current HOD
40 Policy)

Fiscal Note: Less than \$500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-23)

Introduced by: American Association of Clinical Urologists, American Urological Association

Subject: Pharmacists Prescribing for Urinary Tract Infections

Referred to: Reference Committee B

1 Whereas, American Medical Association Policy D-35.987 Evaluation of the Expanding Scope of
2 Pharmacist's Practice opposes federal and state legislation allowing pharmacists to
3 independently prescribe or dispense prescription medication without a valid order by, or under
4 supervision of a licensed doctor of medicine, osteopathy, dentistry or podiatry; and
5
6 Whereas, In 2022/2023 several states including Virginia, Oklahoma, Connecticut, Mississippi,
7 New Mexico and Montana introduced bills to their state legislatures allowing pharmacists to
8 order, test, screen, and treat many health conditions including urinary tract infections; and
9
10 Whereas, The diagnosis of urinary tract infections can be extremely nuanced and is one of the
11 most erroneously diagnosed conditions for which physicians are consulted; and
12
13 Whereas, Underdiagnosis of the severity of urinary tract infections may miss important
14 associated clinical situations such as: kidney or ureteral stones, ureteropelvic junction
15 obstruction, malignant obstruction, etc., which can lead to urinary sepsis and death; and
16
17 Whereas, Misdiagnosis of genitourinary symptoms such as dysuria, pain, or blood in the urine
18 as a common urinary tract infection may miss non-infectious conditions such as interstitial
19 cystitis, overactive bladder, neurogenic bladder, multiple sclerosis, cancer, etc.; and
20
21 Whereas, Pharmacists may not recognize clinical symptoms indicating the presence of foreign
22 bodies within the urinary system, infectious stones, urinary fistulae or diverticula, etc.; and
23
24 Whereas, Urinary tract infections are also one of the most significant sources of antibiotic
25 resistance due to inappropriately prescribed antibiotics. The inability to follow resistance
26 patterns and trends in laboratory results impairs the ability of pharmacists to appropriately
27 prescribe antibiotics; and
28
29 Whereas, AUA guidelines recommend treating urinary tract infections based on a complete
30 patient evaluation including history, pertinent physical examination, appropriate laboratory
31 evaluation and physician follow-up; and
32
33 Whereas, Physicians possess the knowledge, training, experience, and tools to responsibly
34 prescribe antibiotics for urinary tract infections without adding to the ongoing issue of bacterial
35 resistance; therefore be it
36
37 RESOLVED, That our American Medical Association collaborate with relevant stakeholders
38 including state and specialty societies to oppose legislation or regulation allowing pharmacists
39 to test, diagnose, and treat urinary tract infections (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract infections with
- 2 antibiotics is a public health concern which can lead to further bacterial antibiotic resistance.
- 3 (Directive to Take Action)

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

Received: 3/14/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-23)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

1 Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by
2 state and local courts to support individuals with mental illness in the justice system¹⁻⁷; and
3

4 Whereas, Mental health courts connect individuals with mental illness to mental health
5 treatment, as an alternative to incarceration or other legal sentences and penalties¹⁻⁷; and
6

7 Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and
10 resources in the justice system and to establish grants to fund mental health court programs⁸⁻⁹;
11 and
12

13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been
14 dependent on Congressional appropriations¹⁰; and
15

16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)
18 in the Department of Justice administer grants to fund state and local mental health courts^{11,12};
19 and
20

21 Whereas, Research demonstrates that mental health courts appear to be associated with
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and
23 rehospitalization among individuals with mental illness in the justice system^{3,13-26}; and
24

25 Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals
26 who come into contact with the criminal justice system appear” before municipal courts and
27 “many of these individuals have mental illness and co-occurring substance use disorders,”
28 municipal courts may be an especially effective “and often overlooked” method of diversion of
29 individuals with mental illness from the justice system²⁶; and
30

31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,
33 the National Sheriffs’ Association, the Council on State Governments, and the National Center
34 for State Courts, support the use of mental health courts^{2,27-32}; and
35

36 Whereas, While several hundred mental health courts exist across all 50 states, mental health
37 courts do not exist in all counties and localities, indicating that these programs may not be
38 accessible or available to all individuals who could benefit from them⁴; and

1 Whereas, Because mental health courts are dependent on participation from national, state, and
2 local governmental agencies, justice systems, and mental health service organizations and on
3 the appropriation of public funds, including federal monies for MIOTCRA programs and grants
4 administered by SAMHSA and BJA¹⁰⁻¹², the AMA can play a role in advocating for the continued
5 support and funding of mental health courts by policymakers; and
6

7 Whereas, Courts that connect individuals with mental illness to treatment as an alternative to
8 incarceration exist under many different names, with each focused on different types of mental
9 illness, including “mental health courts” (for mental illness in general), “drug courts” (for
10 substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and
11 sometimes certain other substance use disorders)³²⁻³⁵; and AMA policy should be inclusive of all
12 these different types; and
13

14 Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts,
15 which are similar in function to mental health courts but narrower in scope, “for individuals with
16 addictive disease who are convicted of nonviolent crimes”; and
17

18 Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran
19 courts, which are similar in function to mental health courts but narrower in scope, “for veterans
20 who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and
21

22 Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution
23 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with
24 previous Policy H-100.955 on drug courts³⁶⁻³⁷; and
25

26 Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was
27 extracted in our HOD to remove the restriction on only using veteran courts for nonviolent
28 offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could
29 potentially be used for criminal offenses in general and not only for nonviolent offenses³⁶; and
30

31 Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955
32 on drug courts and any future AMA policy on alternatives to incarceration for individuals with
33 mental illness should not be limited to only nonviolent offenses; therefore be it
34

35 RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be
36 amended by addition and deletion as follows:
37

38 **Support for Mental Health Drug Courts, H-100.955**

39 Our AMA: (1) supports the establishment and use of mental health
40 drug courts, including drug courts and sobriety courts, as an effective
41 method of intervention within a comprehensive system of community-
42 based supports and services for individuals with mental illness
43 involved in the justice system ~~addictive disease who are convicted of~~
44 ~~nonviolent crimes~~; (2) encourages legislators to establish mental
45 health drug courts at the state and local level in the United States;
46 and (3) encourages mental health drug courts to rely upon evidence-
47 based models of care for those who the judge or court determine
48 would benefit from intervention rather than incarceration. (Modify
49 Current HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

Support for Veterans Courts H-510.979

Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

Citation: Res. 202, I-19;

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16;

Prevention of Impaired Driving H-30.936

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and

safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

Citation: (CCB/CLRPD Rep. 3, A-14)

E-9.7.2 Court-Initiated Medical Treatment in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

Issued: 2016

E-2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
 - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patient's views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
 - (i) the pain and suffering associated with the intervention;

- (ii) the degree of and potential for benefit;
 - (iii) impairments that may result from the intervention;
 - (iv) quality of life as experienced by the patient.
 - (f) Consult an ethics committee or other institutional resource when:
 - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
 - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
 - (iii) the physician judges that the surrogate's decision:
 - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
 - b. could not reasonably be judged to be in the patient's best interest; or
 - c. primarily serves the interests of the surrogate or other third party rather than the patient.
- Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-23)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

1 Whereas, In 2019, 197.5 million Americans (71.8%) aged 12 and over used a substance in
2 the past year, with 179 million using alcohol, 72 million using tobacco, and 57.2 million using
3 an illicit drug, including 9.7 million using prescription opioids, 6 million using hallucinogens,
4 5.9 million using prescription tranquilizers or stimulants, 5.5 million using cocaine, 2 million
5 using methamphetamine, and 745,000 using heroin¹; and
6

7 Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past
8 year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million
9 Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug¹; and
10

11 Whereas, The US classifies controlled substances into five schedules, but significant
12 controversy exists over the schedules of certain drugs deemed to have “no medical use,”
13 despite research showing that these drugs may have therapeutic potential²⁻⁵; and
14

15 Whereas, Sentences and penalties for federal and state drug offenses vary depending on the
16 drug’s schedule, amount of drug, circumstances of arrest, and previous drug convictions and
17 criminal record⁶⁻⁸; and
18

19 Whereas, Drug possession is defined as being found with an amount of a drug small enough
20 for personal use (as determined by the government) without legal justification⁶⁻⁸; and
21

22 Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and
23 can be punishable by up to 1 year imprisonment and/or at least \$1,000 in fines for a first-time
24 offense and up to 3 years imprisonment and/or \$5,000 in fines for repeat offenses, with
25 greater sentences and penalties depending on amount of drug, previous drug convictions,
26 and criminal record⁷⁻⁸; and
27

28 Whereas, State statutes are most commonly used to charge people with drug possession
29 and these statutes vary significantly, with many states (including Indiana, Kentucky, and
30 Oklahoma) reclassifying possession from felonies to misdemeanors over the last decade,
31 lowering mandatory minimums, and using savings from reduced incarceration to fund social
32 services, while many other states (such as Idaho, Missouri, and Nebraska) continue to
33 charge possession as felonies often punished with multiple years of imprisonment⁹⁻¹³; and
34

35 Whereas, In some states, multiple drug felony convictions can result in being charged with a
36 “violent offense,” despite no physical violence being committed against any person, which
37 can further increase sentences and penalties and limit eligibility for parole¹⁴; and
38

39 Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over
40 80% of all drug offense arrests, and possession arrests drastically increased alongside

1 changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even
2 as arrests for drug distribution and manufacture remained relatively stable since 1990¹⁵⁻¹⁶;
3 and
4

5 Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated
6 for “nonviolent drug offenses,” including 120,000 unconvicted awaiting trial¹⁶; and
7

8 Whereas, Defelonization refers to the reclassification of an offense from a felony to a
9 misdemeanor, reduces the probability and potential length of imprisonment and decreasing
10 the long-term harms associated with incarceration¹⁷⁻¹⁹; and
11

12 Whereas, “Decriminalization” is distinct from legalization and only refers to the removal of
13 criminal charges associated with drug possession and its reclassification as a civil infraction,
14 which is a prohibited action that results in civil penalties and sanctions against a person¹⁷⁻²⁰;
15 and
16

17 Whereas, “Legalization” would move beyond decriminalization by eliminating civil infractions
18 for drug possession and creating a regulatory system to control legal production and sale of
19 drugs to adults without a prescription, as with alcohol and tobacco¹⁷⁻²⁰; and
20

21 Whereas, AMA Policy H-95.924, “Cannabis Legalization for Adult Use,” states that our AMA
22 “supports public health based strategies, rather than incarceration,” and the AMA Council on
23 Science & Public Health’s Interim 2020 report on cannabis states that “AMA policy supports
24 decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a
25 small amount of cannabis from a criminal offense subject to arrest to a civil infraction)”²¹; and
26

27 Whereas, Various states are considering policies to expunge (destroy) certain offenses (such
28 as drug offenses, especially those due to cannabis) from a person’s criminal record after
29 completion of sentences and penalties, but expungement processes can still be costly and
30 complicated, hindering eligible people from applying (for example, expungement in Missouri
31 costs \$250)²²⁻²⁶; and
32

33 Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed
34 by the US House of Representatives in December 2020 but has not yet been considered in
35 the Senate, contains language to “create an automatic process, at no cost to the individual,
36 for the expungement, destruction, or sealing of criminal records for cannabis offenses;
37 and...eliminate violations or other penalties for persons under parole, probation, pre-trial, or
38 other State or local criminal supervision for a cannabis offense”²⁷⁻²⁸; and
39

40 Whereas, The US Department of Health & Human Services’ Healthy People 2020 initiative
41 considers incarceration a key issue within the broad category of social determinants of
42 health, due to poor physical and mental health outcomes and cross-generational effects on
43 the children of those incarcerated, with evidence demonstrating the disproportionate impact
44 of the “War on Drugs” on minoritized communities²⁹⁻³¹; and
45

46 Whereas, While only 5% of people who use drugs are Black, arrests of Black people
47 comprise nearly 30% of all drug arrests, and Black people are nearly six times more likely to
48 be arrested for a drug offense than a white person, even when controlling for differences in
49 drug use, exacerbating racial injustice^{32,33}; and

1 Whereas, Research shows that incarceration is ineffective and does not significantly reduce
2 recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state
3 study finding that overdose was the leading cause of death for people previously
4 incarcerated³⁴⁻³⁶; and
5

6 Whereas, Drug criminalization is associated with increased stigma and discrimination against
7 people who use drugs, impairing their mental and physical health and hindering treatment
8 efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and
9 detrimentally affected public health by increasing overdose deaths due to drug contamination
10 and spreading HIV and hepatitis C³⁷⁻⁴¹; and
11

12 Whereas, Previous incarceration of people who use drugs is associated with lack of access to
13 health insurance, even after the implementation of the Affordable Care Act, while possession
14 arrests, regardless of conviction, can negatively impact employment, housing, and student
15 loan eligibility, leading to widespread and multifactorial health consequences⁴²⁻⁴⁴; and
16

17 Whereas, Drug felony convictions can lead to lifelong bans from receiving government
18 assistance (such as SNAP and TANF), employment and housing discrimination, and loss of
19 the right to vote or serve on a jury^{7,45-48}; and
20

21 Whereas, People who are incarcerated are at higher risk of chronic conditions such as
22 cardiovascular disease, hypertension, and cancer compared to the general population, with
23 an important 2013 New York state study finding that each year spent in prison corresponded
24 with a two-year decline in life expectancy^{49,50}; and
25

26 Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to
27 incarceration, encouraging more dangerous drug consumption methods, and discouraging
28 people from receiving health services⁵¹⁻⁵³; and
29

30 Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support
31 “eliminating criminal penalties for drug possession,” and 61% of voters support reducing
32 sentences of people currently incarcerated for drug offenses, with similar findings replicated
33 across multiple states⁵⁴⁻⁵⁸; and
34

35 Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by
36 passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading
37 to the release or resentencing of 3,000 people and saving the state \$156 million, with a later
38 study finding no associated increase in crime⁵⁹⁻⁶³; and
39

40 Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an
41 increase in the prevalence of youth cannabis use as a result of decriminalization⁶⁴; and
42

43 Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a
44 comprehensive policy review determined that criminal penalties did not reduce use or harm
45 and were instead costly and unjustifiable, with later studies demonstrating net societal
46 benefits without increased rates of drug use^{65,66}; and
47

48 Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-
49 related seizures, HIV and drug-related deaths, and decreased societal costs related to drug
50 use^{67,68}; and

1 Whereas, In 2019 the United Nations Chief Executives Board for Coordination issued a
2 statement calling for the “promot[ion of] alternatives to conviction and punishment in
3 appropriate cases, including the decriminalization of drug possession for personal use”^{18,69};
4 and
5

6 Whereas, Decriminalization of personal use and possession of drugs is supported by the
7 World Health Organization, American Public Health Association, Human Rights Watch,
8 Global Commission on Drug Policy, International Federation of Red Cross and Red Crescent
9 Societies, NAACP, and National Latino Congress⁷⁰⁻⁷⁶; therefore be it

10
11 RESOLVED, That our American Medical Association advocate for federal and state
12 reclassification of drug possession offenses as civil infractions and the corresponding
13 reduction of sentences and penalties for individuals currently incarcerated, monitored, or
14 penalized for previous drug-related felonies (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA support federal and state efforts to expunge criminal records for
17 drug possession upon completion of a sentence or penalty at no cost to the individual (New
18 HOD Policy); and be it further
19

20 RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based
21 penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug
22 possession. (New HOD Policy)
23

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

Received: 3/27/23

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RELEVANT AMA POLICY

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

Citation: BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20;

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement

policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use of cannabis and cannabinoids. Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20;

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

Youth Incarceration in Adult Facilities H-60.916

1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.
2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.

Citation: Alt. Res. 917, I-16;

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

Syringe and Needle Exchange Programs H-95.958

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and

possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Pilot Implementation of Supervised Injection Facilities H-95.925

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-23)

Introduced by: Medical Student Section
Subject: Supporting Harm Reduction
Referred to: Reference Committee B

1 Whereas, In 2016 it was estimated that 26.8 million people were living with opioid use disorder
2 (OUD) worldwide, almost 10% of whom (2.1 million) were living in the USA^{1,2}; and
3

4 Whereas, Those with OUD are at increased risk of long term negative outcomes including
5 overdose; fatal overdoses involving opioids in the USA have almost quadrupled in the past
6 decade with 80,411 deaths in 2021 alone^{1,3}; and
7

8 Whereas, Medications for OUD (MOUD), which include the opioid agonist treatments (OAT)
9 buprenorphine and methadone in addition to the opioid antagonist naltrexone, are the gold-
10 standard for treating OUD and are associated with decreased risk of negative outcomes
11 including overdose^{4,5}; and
12

13 Whereas, In the US, over 70% of those who need treatment for OUD do not receive it and this is
14 often a result of a lack of access to adequate (or any) treatment services; only 36% of
15 substance use disorder (SUD) treatment facilities offer at least one MOUD, and just 6.1% offer
16 access to all three^{6,7}; and
17

18 Whereas, Even if patients gain access to MOUD, not all of them will keep that access long
19 enough for therapeutic efficacy; prior to implementing a low-barrier MOUD chronic treatment
20 philosophy of “MedFirst” in Missouri, only 17% of uninsured patients receiving treatment for
21 OUD were prescribed buprenorphine and of these patients, 78% received the medication for
22 fewer than 5 months⁸; and
23

24 Whereas, The COVID-19 pandemic has exacerbated and amplified pre-existing barriers to
25 MOUD access by prompting closures of OUD treatment services, transitions to telehealth visits,
26 fears of COVID-19 exposure during methadone treatments, and changes in MOUD regulations⁹;
27 and
28

29 Whereas, Deaths from opioid overdose increased dramatically during the COVID-19 pandemic;
30 for example, the state of Kentucky saw a 50% increase in emergency medical service runs for
31 deaths from suspected overdoses^{10,11}; and
32

33 Whereas, In one study, only 76% of subjects were able to remain adherent to their
34 buprenorphine regimen during the COVID-19 pandemic with inadequate access to treatment
35 serving as a key obstacle¹²; and
36

37 Whereas, One consequence of inadequate treatment access is that people with OUD may
38 attempt to self-medicate with street-purchased MOUD such as buprenorphine for the purposes
39 for treatment; studies have repeatedly demonstrated that the majority of people who use non-

1 prescribed buprenorphine do so in a manner consistent with therapeutic treatment for
2 withdrawal sickness or attempts to reduce opioid use¹³⁻¹⁵; and

3
4 Whereas, Studies show that illicit buprenorphine is rarely used recreationally due to its partial
5 agonist effects and extremely low potential for overdose; US surveys have indicated that of
6 those with OUD who reported using illicit buprenorphine, 97% used it to prevent cravings and
7 90% used it to prevent withdrawal symptoms¹⁵⁻²³; and

8
9 Whereas, Motivators for use of unprescribed buprenorphine include: to prevent withdrawal, to
10 maintain abstinence or weaning off drugs, to avoid the overly stringent demands of formal
11 treatment, to prepare for formal treatment, to gain a sense of self-determination and agency in
12 recovery, and to use while geographically relocating; the majority of respondents to a global
13 survey indicated they would prefer using prescribed buprenorphine if they could^{13,21}; and

14
15 Whereas, Some physicians are hesitant to prescribe buprenorphine due to concerns over its
16 potential diversion and potential for subsequent prosecution of those involved, which may hold
17 the prescribing physician accountable²⁴; and

18
19 Whereas, Current legislation indicates that a person in possession of buprenorphine not
20 prescribed to them is guilty of the misdemeanor crime of possession of a narcotic, which can
21 result in arrest and jail time²⁵; and

22
23 Whereas, Criminal justice solutions to OUD are not effective and at present only 4.6% of those
24 with OUD referred to treatment by the criminal justice system are given the gold-standard opioid
25 agonist therapies, versus 40.9% of those referred to treatment from elsewhere²⁶; and

26
27 Whereas, Although people with OUD are overrepresented in the criminal justice system, few
28 criminal justice systems use validated tools to screen those entering for OUD or provide full
29 access to MOUD to those who are incarcerated thereby impairing individuals access to
30 treatment²⁷⁻³¹; and

31
32 Whereas, In 2018, Chittenden County in Vermont implemented several evidence-based
33 interventions including: access to buprenorphine at its syringe exchange and emergency
34 departments, elimination of the waitlist for MOUD, and decriminalization and a non-arrest policy
35 for the possession of non-prescribed buprenorphine; these resulted in a 50% decline in opioid
36 overdose deaths despite overdose deaths increasing by 20% in the remainder of the state^{24,25};
37 and

38
39 Whereas, In 2020, following the success of the Chittenden County intervention, the Philadelphia
40 District Attorney's Office announced that people will no longer be arrested or prosecuted for the
41 possession of non-prescribed buprenorphine-based medications^{32,33}; and

42
43 Whereas, Removal of buprenorphine from the misdemeanor list, as opposed to full
44 decriminalization, would eliminate consequences such as jail time and probation but may still
45 result in an infraction, which burdens the person accused with fines, an appearance in court,
46 and possible remediation requirements³⁴⁻³⁶; and

47
48 Whereas, As opposed to misdemeanors and felonies, when charged as a civil infraction,
49 possession of substances are generally not visible under background checks but may still be
50 listed as public records³⁷; and

1 Whereas, Our existing AMA policy (D-95.987) does not address the legal designation of
2 unprescribed buprenorphine possession thus the policy will not allow our AMA to advocate for
3 the decriminalization of buprenorphine nor for its removal from the misdemeanor list; and
4

5 Whereas, It is important to update our AMA policy to allow for the most up to date advocacy
6 (such as supporting State bill H.225 introduced in February 2021 from Vermont to decriminalize
7 therapeutic dosage of buprenorphine), especially in the midst of rising number of overdoses
8 during the COVID-19 pandemic³⁸; and
9

10 Whereas, Another method for harm reduction is safer smoking, wherein tools to more safely
11 consume drugs via smoking, including glass stems and pipes, plastic mouthpieces for burn
12 prevention, screens, wooden push sticks, and alcohol wipes, are provided to patients^{39,40}; and
13

14 Whereas, Providing safer smoking supplies at syringe service programs provides individuals
15 with a safer alternative to injection drug use, thus reducing risk of overdose, soft tissue
16 infections and endocarditis, and risk of infectious disease transmission (including Hepatitis C
17 and HIV) from injection drug use³⁹⁻⁴⁴; and
18

19 Whereas, Providing safer smoking supplies has been shown to reduce risky smoking
20 behaviors^{45,46}; and
21

22 Whereas, Lack of access to new pipes is a reported reason why people who use drugs use
23 damaged pipes, report sharing pipes, or use self-made pipes^{47,48}; and
24

25 Whereas, Self-made pipes increase risk for injury and chemical burns inside the mouth and
26 near the lips since materials such as plastic bottles or tin cans can give off toxic vapors and
27 cause respiratory damage^{49,50}; and
28

29 Whereas, A 2017 study by Prangnell et al in the *BMC Public Health* journal evaluated rates of
30 health problems associated with crack smoking during the expansion of safer smoking kit
31 distribution in Vancouver, Canada, and found that study participants who obtained safer
32 smoking kits were significantly less likely to report health problems from smoking crack than
33 participants who made their own pipes or acquired them elsewhere⁵¹; and
34

35 Whereas, International studies elsewhere in North America and abroad demonstrate the harm
36 reduction efficacy of safer smoking kits⁵⁰⁻⁵⁴; and
37

38 Whereas, The sale, import, and export of safer smoking supplies is illegal under Title 21 U.S.
39 Code 863 – Drug paraphernalia, which prevents syringe service programs and other harm
40 reduction programs from distributing them, and prevents the allocation of public funds for their
41 distribution^{39,46,55}; and
42

43 Whereas, AMA policy D-95.987 supports the “continued study and implementation of
44 appropriate treatments and risk mitigation methods for patients at risk for opioid overdose”;
45 therefore be it
46

47 RESOLVED, That our American Medical Association advocate for the removal of buprenorphine
48 from the misdemeanor crime of possession of a narcotic (Directive to Take Action); and be it
49 further
50

51 RESOLVED, That our AMA support any efforts to decriminalize the possession of non-
52 prescribed buprenorphine (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend Policy D-95.987 by addition and deletion to read as
2 follows:

3
4 **Prevention of Drug-Related Overdose, D-95.987**

5 1. Our AMA: (a) recognizes the great burden that substance
6 use disorders (SUDs) and drug-related overdoses and death
7 places on patients and society alike and reaffirms its support
8 for the compassionate treatment of patients with a SUD and
9 people who use drugs; (b) urges that community-based
10 programs offering naloxone and other opioid overdose and
11 drug safety and prevention services continue to be
12 implemented in order to further develop best practices in this
13 area; (c) encourages the education of health care workers and
14 people who use drugs about the use of naloxone and other
15 harm reduction measures in preventing opioid and other drug-
16 related overdose fatalities; and (d) will continue to monitor the
17 progress of such initiatives and respond as appropriate.

18 2. Our AMA will: (a) advocate for the appropriate education of
19 at-risk patients and their caregivers in the signs and symptoms
20 of a drug-related overdose; and (b) encourage the continued
21 study and implementation of appropriate treatments and risk
22 mitigation methods for patients at risk for a drug-related
23 overdose.

24 3. Our AMA will support the development and implementation
25 of appropriate education programs for persons receiving
26 treatment for a SUD or in recovery from a SUD and their
27 friends/families that address harm reduction measures.

28 4. Our AMA will advocate for and encourage state and county
29 medical societies to advocate for harm reduction policies that
30 provide civil and criminal immunity for the possession,
31 distribution, and use of "drug paraphernalia" designed for harm
32 reduction from drug use, including but not limited to drug
33 contamination testing, safer smoking, and injection drug
34 preparation, use, and disposal supplies.

35 5. Our AMA will implement an education program for patients
36 with substance use disorder and their family/caregivers to
37 increase understanding of the increased risk of adverse
38 outcomes associated with having a substance use disorder and
39 a serious respiratory illness such as COVID-19.

40 6. Our AMA will advocate for supports efforts to increased
41 access to and decriminalization of fentanyl test strips, and other
42 drug checking supplies, and safer smoking kits for purposes of
43 harm reduction. (Modify Current HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

Treating Opioid Use Disorder in Hospitals D-95.967

1. Our AMAs Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.

2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

Citation: Res. 223, A-18;

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972

1. Our AMAs Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Citation: Res. 506, A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17;

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944

Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

Citation: Res. 710, A-13; Reaffirmed in lieu of: Res. 228, I-18;

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Citation: BOT Rep. 11, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Opioid Mitigation H-95.914

Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.

Citation: BOT Rep. 09, I-19;

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19;

Syringe and Needle Exchange Programs H-95.958

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Citation: Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13; Modified: Res. 914, I-16;

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is

urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-23)

Introduced by: Medical Student Section

Subject: Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness

Referred to: Reference Committee B

1 Whereas, The rates of chronically homeless sheltered individuals have increased by 20%
2 between 2020 and 2021, particularly in high cost cities and suburbs, driven by factors including,
3 but not limited to, the implications of the COVID-19 pandemic, a tightening housing market, and
4 reductions in social services¹⁻³; and

5
6 Whereas, Housing market demand has exceeded pre-pandemic levels of supply, and new
7 construction cannot fill the large gap in the short term due to increases in second-home buying²;
8 and

9
10 Whereas, Despite unprecedented levels of federal, state, and local support during the COVID-
11 19 pandemic, the number of individuals experiencing chronic homelessness increased by 15%
12 between 2020 and 2022⁴; and

13
14 Whereas, In major metropolitan areas, rents have increased by more than 30% between
15 January 2021 to January 2022, placing lower income families, individuals, and veterans at an
16 increased risk for eviction and homelessness⁵⁻⁷; and

17
18 Whereas, The Department of Housing and Urban Development found median rent increases of
19 \$100 per month were associated with a 9% increase in homelessness in the metropolitan areas
20 they examined⁸; and

21
22 Whereas, At-risk populations, including low-income households, minorities, veterans, and adults
23 over the age of 65 are especially vulnerable to the impacts of uncontrolled rent increases, job
24 insecurity in sectors most affected by the pandemic (i.e., leisure and hospitality; food, clothing,
25 and other goods), and medical debt^{3,5,9}; and

26
27 Whereas, A report by the National Coalition of Asian Pacific American Community Development
28 in March 2021 revealed eviction moratoriums would affect 26% of Asian and 27% of Native
29 Hawaiians or Other Pacific Islander (NHOPI) renters and 16% of Asian and 12% of NHOPI
30 homeowners who are severely cost-burdened (i.e., greater than 50% of their income is spent on
31 housing)¹⁰; and

32
33 Whereas, Severely cost-burdened Asian Pacific Islander American communities are especially
34 at risk for eviction and subsequent homelessness as more than half (54%) of Asian households
35 have limited English proficiency compared to white households (9%)¹⁰; and

36
37 Whereas, Between 2020 and 2021, unaccompanied transgender, gender non-conforming, and
38 Native American youths (under the age of 25) experienced dramatic increases in the rates of
39 homelessness of 29%, 26%, and 21%, respectively¹; and

1 Whereas, Youths (under the age of 25) experiencing homelessness who identify as a minority,
2 LGBTQ+, refugee, and/or immigrant are more likely to suffer from an increased number of
3 health disparities, including malnutrition, asthma, obesity, mood disorders, anxiety, physical and
4 emotional abuse, post-traumatic stress, developmental delays, high-risk sexual behaviors, drug
5 use, and rape, compared to their stably housed peers^{11,12}; and
6

7 Whereas, Maternal and child health is significantly impacted by homelessness with increases in
8 adverse childhood experiences, depressive symptoms, and negative effects on both mental and
9 physical well-being¹³; and
10

11 Whereas, The costs of healthcare for individuals suffering from homelessness tend to be
12 disproportionately high when compared to others receiving healthcare with increases in
13 Veterans Affairs and Medicare utilization and cost^{14,15}; and
14

15 Whereas, One study conducted over six years in California found that connecting frequent users
16 of the emergency department to housing reduced their healthcare costs overall by 59%,
17 decreased their emergency department costs by 61%, and reduced the number of inpatient
18 hospitalizations by 77%^{16,17}; and
19

20 Whereas, Homelessness is a public health problem associated with increased mortality (where
21 one in three homeless deaths are due to preventable causes), increased prevalence of acute
22 and chronic health conditions, and increased behavioral and mental health conditions with
23 nearly 23% of homeless persons reporting having mental health conditions compared to 3% of
24 never homeless persons^{18,19}; and
25

26 Whereas, Feasible solutions to the homelessness crisis include rent-control laws that protect
27 tenants that are unable to afford their rental payments and just cause eviction statutes that
28 protect residents from being arbitrarily evicted^{20,21}; and
29

30 Whereas, Cities that have implemented just cause eviction statutes have lower rates of eviction
31 and filings (-0.808% points and -0.780% points respectively)²¹; and
32

33 Whereas, Right to counsel policies would ensure legal counsel representation for tenants in
34 eviction proceedings, and the creation of local, state, and/or national rental registries to monitor
35 tenant and landlord contracts and prevent unlawful evictions²⁰; and
36

37 Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-
38 20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to
39 adequate health care for people experiencing homelessness through methods such as waiving
40 co-pays, or providing care through free clinics; and
41

42 Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on
43 regional variations, community characteristics and state and local resources are necessary to
44 address [homelessness] on a long-term basis”, and as such has set precedence for feasibly
45 supporting such measures; therefore be it
46

47 RESOLVED, That our American Medical Association recognize and support the use of Street
48 Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and
49 deletion to read as follows:

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) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;

(5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(7) 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;

(8) 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;

(9) 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;

(10) (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

(11) 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;

- 1 (12) (a) supports training to understand the needs of housing
2 insecure individuals for those who encounter this vulnerable
3 population through their professional duties; (b) supports the
4 establishment of multidisciplinary mobile homeless outreach
5 teams trained in issues specific to housing insecure individuals;
6 and (c) will make available existing educational resources from
7 federal agencies and other stakeholders related to the needs of
8 housing-insecure individuals-;
9 (13) encourages medical schools to implement physician-led,
10 team-based Street Medicine programs with student
11 involvement-; and
12 (14) supports federal and state efforts to enact just cause eviction
13 statutes and examine and restructure punitive eviction practices;
14 instate inflation-based rent control; guarantee tenants' right to
15 counsel in housing disputes and improve affordability of legal fees;
16 and create national, state, and/or local rental registries. (Modify
17 Current HOD Policy)
18

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

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RELEVANT AMA POLICY

Housing Insecure Individuals with Mental Illness 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; Reaffirmed: Res. 414, A-22;

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; Reaffirmed: Res. 414, A-22;

E-11.1.4 Financial Barriers to Health Care Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation,

(a) Individual physicians should:

- (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Public Health Authority

Referred to: Reference Committee B

1 Whereas, American Indian and Alaska Native Tribes and Villages (“Tribal Nations”) and Tribal
2 Epidemiology Centers (TECs) are “public health authorities” under federal law at 25 U.S.C.
3 §1621m and federal regulation at 45 C.F.R. § 164.501¹; and
4

5 Whereas, Tribal Nations and TECs have the legal authority to collect, receive, and disseminate
6 public health data as necessary to respond to public health threats¹; and
7

8 Whereas, As such, Tribal Nations and TECs have the same public health authority designation
9 as, for example, the United States (US) Centers for Disease Control and Prevention (CDC), and
10 state and local health departments¹; and
11

12 Whereas, Despite their recognition as public health authorities, Tribal Nations and TECs have
13 varying access to data from the CDC and the Indian Health Service (IHS)²; and
14

15 Whereas, The U.S. Government Accountability Office, in a 2022 report, found a lack of policies
16 affirming Tribal Nations and TECs' authority to access CDC and IHS data, guidance for TECs
17 on how to request data, and agency procedures on how to respond to such requests²; and
18

19 Whereas, During the COVID-19 pandemic, reports emerged that county and state public health
20 agencies refused to share case and mortality data with Tribal Nations and TECs in California
21 and the Great Plains Area, citing a lack of authority to access such data and restrictions outlined
22 by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)³⁻⁴; and
23

24 Whereas, As public health authorities, Tribal Nations and TECs are authorized to access and
25 manage HIPAA-inclusive data, given that they are Covered Entities⁵⁻⁶; and
26

27 Whereas, By preventing Tribal Nations and TECs from accessing their public health data, local
28 and state governments and federal agencies like the IHS, infringe upon Tribal sovereignty and
29 do not give special attention to the health and health-related needs of American Indians and
30 Alaska Natives, potentially harming their quality of life and healthcare outcomes (AMA Policy H-
31 350.976); therefore be it
32

33 RESOLVED, That our American Medical Association advocate to achieve enactment of reforms
34 to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status
35 as public health authorities (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA make a suggestion to the Department of Health and Human
38 Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated
39 data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal
40 Epidemiology Centers (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA encourage the use of data-sharing agreements between local and
- 2 state public health departments and American Indian and Alaska Native Tribes and Villages and
- 3 Tribal Epidemiology Centers. (New HOD Policy)

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

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RELEVANT AMA POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.

Citation: Res. 407, I-20; Modified: CSAPH Rep. 2, I-21; Reaffirmed: CMS Rep. 5, A-22;

Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data H-406.998

Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness; (2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data; (3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and

practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data; (4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data; (5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities; (6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and (7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.

Citation: (BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed: CMS Rep. 1, A-15)

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

- (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
 - (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
 - (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
 - (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
 - (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
 - (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
 - (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
 - (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
 - (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
- Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Plan for Continued Progress Toward Health Equity H-180.944

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

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21;

Universal Access for Essential Public Health Services D-440.924

Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions.

Citation: Res. 419, A-19; Modified: CSAPH Rep. 2, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-23)

Introduced by: Medical Student Section

Subject: Ground Ambulance Services and Surprise Billing

Referred to: Reference Committee B

- 1 Whereas, Emergency Medical Services (EMS) and ground ambulance services play a critical
2 role in the network of healthcare in each community¹; and
3
4 Whereas, People insured under Medicare or Medicaid are not at risk for surprise billing²; and
5
6 Whereas, Ten percent of emergency room visits for privately insured individuals require an
7 ambulance ride to the hospital³; and
8
9 Whereas, Anywhere from 71-86% of ground ambulance rides involve potential surprise bills with
10 patients being charged an aggregate of \$129 million per year due to out-of-network charges^{1,4};
11 and
12
13 Whereas, 39% of Americans would struggle to cover an unexpected expense of just \$400⁵; and
14
15 Whereas, Eight percent of all medical debt stems from ambulance charges⁶; and
16
17 Whereas, Medical debt disproportionately impacts poor and minority communities, with 80% of
18 medical debt being held by households with zero or negative net worth, and 27% of Black
19 households holding medical debt compared to only 17% of non-black households⁷; and
20
21 Whereas, EMS and ambulance service reimbursement from governmental sources is inadequate
22 and subject to significant year-to-year fluctuations⁴; and
23
24 Whereas, Patients bear a disproportionate and unintentional financial burden due to out-of-
25 network ambulance service charges⁸; and
26
27 Whereas, Financial concerns have been linked to reduced utilization of ground ambulance
28 services, increasing risk of morbidity and mortality⁹; and
29
30 Whereas, Low-income patients are 160% more likely to utilize emergency medical services when
31 cost concerns are eliminated¹⁰; and
32
33 Whereas, Only Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont,
34 West Virginia have protections against ground ambulance surprise billing¹¹; and
35
36 Whereas, The No Surprises Act supplements existing state surprise billing laws to protect patients
37 from receiving surprise medical bills by requiring private health plans to cover eligible out-of-
38 network costs, and by prohibiting covered healthcare providers from billing more than the in-
39 network cost-sharing amount¹²⁻¹⁴; and

1 Whereas, The No Surprises Act called for the creation of a “Ground Ambulance and Patient
2 Billing” advisory committee in January 2022 to develop recommendations on how to address
3 surprise billing in the context of ground ambulance services, but has neither chosen representing
4 members nor published a meeting date^{11,15}; and
5

6 Whereas, The No Surprises Act addresses air ambulance services by including “medical transport
7 by helicopter” and “medical transport by airplane”, but does not include ground ambulance
8 services¹⁶⁻¹⁷; therefore be it
9

10 RESOLVED, That our American Medical Association oppose surprise billing practices for ground
11 ambulance services. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22;

Billing Procedures for Emergency Care H-130.978

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Citation: (CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.

Citation: BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Balance Billing for All Physicians D-380.996

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17;

Medicare Balance Billing D-390.986

Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Citation: Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22;

Balance Billing H-385.991

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16;

Freedom of Choice H-390.854

(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

Medicare's Ambulance Service Regulations H-240.978

1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patients needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Citation: Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: Res. 124, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-23)

Introduced by: Medical Student Section

Subject: Medicaid Managed Care for Indian Health Care Providers

Referred to: Reference Committee B

1 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and
2 Human Services, is responsible for providing health services to American Indians and Alaska
3 Natives (AI/AN)¹; and
4

5 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita
6 health care expenditures are \$4,078, while figures for Veterans Healthcare Administration is
7 \$10,692 and Medicaid and Medicare are \$8,109 and \$13,185, respectively²; and
8

9 Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be
10 made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban
11 Indian Health Program to the extent that such provider is eligible to receive payment for the
12 treatment from any other federal, state, local, or private source of reimbursement for which the
13 patient is eligible³; and
14

15 Whereas, IHS' sources of reimbursement include, but are not limited to, Medicare Part A and B,
16 State Medicaid, State or other federal health programs (e.g., Veterans Health Administration),
17 private insurance, and funds from Tribal health programs³; and
18

19 Whereas, Payments for IHS patients' medical care received from public programs such as
20 Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal
21 year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities⁴; and
22

23 Whereas, IHS third-party collections are increasingly important, as they represent a significant
24 portion of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget and are
25 also used to procure services, supplies, and pharmaceuticals⁴⁻⁵; and
26

27 Whereas, An estimated 725,000 AI/AN patients served by the IHS (28.3% of population served)
28 have Medicaid coverage⁵; and
29

30 Whereas, As of July 2021, 41 states, including the District of Columbia, contract with Managed
31 Care Organizations (MCO) to provide for the delivery of Medicaid health benefits and additional
32 services⁶⁻⁷; and
33

34 Whereas, Managed Care Organizations (MCO) play a significant role in the delivery of
35 healthcare to Medicaid enrollees because states choose which populations and services to
36 include in managed care contracts (e.g. persons with disabilities, dual-eligible Medicaid and
37 Medicare beneficiaries)⁷; and

1 Whereas, There are Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. §
2 438.14) protecting the rights of Indian Health Care Providers (IHCP) that must be followed by
3 state Medicaid programs or their contracted MCO⁸; and
4

5 Whereas, An IHCP is a health care program operated by the IHS or by an Indian Tribe, Tribal
6 Organization, or Urban Indian Organization, as those terms are defined in section 4 of the
7 Indian Health Care Improvement Act (25 U.S.C. 1603)⁹; and
8

9 Whereas, These provisions include: (1) allowing AI/AN Medicaid enrollees to obtain MCO-
10 covered services from out-of-network IHCPs; (2) requiring MCOs to pay out-of-network IHCPs
11 that are federally qualified health centers (FQHC) at the same rate that they would pay an in-
12 network FQHC; and (3) requiring MCOs to pay out-of-network IHCPs that are not an FQHC at
13 the IHS rate⁸; and
14

15 Whereas, In 2019, the Center for Medicare and Medicaid Services (CMS) Tribal Technical
16 Advisory Group (TTAG) formed a Managed Care Subcommittee to address Medicaid managed
17 care issues identified by IHCPs, AI/AN Medicaid enrollees, and Tribal leaders⁸; and
18

19 Whereas, Key issues identified by the CMS TTAG Subcommittee included denying AI/AN
20 enrollees the right to receive services from an IHCP of their choice, denial of claims made by
21 IHCPs to MCOs, inadequate State oversight of MCOs, and incorrect reimbursement from MCOs
22 to IHCPs for their services⁸; and
23

24 Whereas, Greater compliance with Indian Health Care Medicaid Managed Care Provisions (42
25 C.F.R. § 438.14) will improve the availability of health care services offered by IHCPs⁹; therefore
26 be it
27

28 RESOLVED, That our American Medical Association urge stronger federal enforcement of
29 Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state
30 Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with
31 their legal obligations to Indian health care providers (New HOD Policy); and be it further
32

33 RESOLVED, That our AMA collaborate with other stakeholders to encourage state Medicaid
34 agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory
35 Group's recommendations to improve care coordination and payment agreements between
36 Medicaid managed care organizations and Indian health care providers by, including, but not
37 limited to:

- 38 1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid
39 agencies.
- 40 2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian
41 Managed Care Addendum.
- 42 3. Offering employee onboarding and annual refresher training regarding Indian Health
43 Care Medicaid Managed Care Provisions. (Directive to Take Action)
44

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

Received: 3/27/23

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RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

- (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
- (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
- (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
- (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
- (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
- (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
- (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
- (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

Monitoring Medicaid Managed Care H-290.985

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.

- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
 - (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
 - (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
 - (15) Preservation of private right of action for physicians and other providers and beneficiaries.
 - (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
 - (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
 - (18) Absence of gag rules.
 - (19) Fairness in procedures for selection and deselection.
 - (20) Realistic payment levels based on costs of care and predicted utilization levels.
 - (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
 - (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.
- Citation: CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 1, I-22;

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

- (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.
- Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-23)

Introduced by: Medical Student Section

Subject: Purchased and Referred Care Expansion

Referred to: Reference Committee B

1 Whereas, The Indian Health Service (IHS), an agency within the United States (U.S.)
2 Department of Health and Human Services, is responsible for providing health services to
3 American Indians and Alaska Natives (AI/AN)¹; and
4

5 Whereas, The IHS is funded each year through appropriations by the U.S. Congress¹; and
6

7 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita
8 health care expenditures are \$4,078, while the Veterans Healthcare Administration is \$10,692
9 and Medicaid and Medicare are \$8,109 and \$13,185, respectively²; and
10

11 Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be
12 made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban
13 Indian Health Program to the extent that such provider is eligible to receive payment for the
14 treatment from any other federal, state, local, or private source of reimbursement for which the
15 patient is eligible³; and
16

17 Whereas, These sources of reimbursement include, but are not limited to, Medicare Part A and
18 B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration),
19 private insurance, and funds from Tribal health programs³; and
20

21 Whereas, AI/AN individuals have the highest rates of uninsurance compared to other racial and
22 ethnic groups, even after passage of the Affordable Care Act, with 48.7% of people served by
23 the Indian Health Service having no insurance coverage⁴; and
24

25 Whereas, IHS, Tribal, and Urban Indian Health Programs are often limited to primary care
26 services due to funding limitations and facility constraints, among other factors⁵; and
27

28 Whereas, The IHS operates the Purchased/Referred Care Program (PRCP), a non-entitlement
29 referral program that may cover medical and dental care provided away from an IHS or Tribal
30 Health Program^{5,7}; and
31

32 Whereas, If the IHS is requested to pay through PRCP, then an AI/AN patient must meet the
33 PRCP residency requirements, notification requirements, medical priority, and use of alternate
34 resources such as private insurance, Medicaid, other sources of health funding⁵; and
35

36 Whereas, PRCP funding is limited, restricting access to non-emergent medical specialty care
37 part-way through the fiscal year unless an AI/AN patient is facing a "life-or-limb" situation⁶⁻⁸; and
38

39 Whereas, Reporting of PRCP claims is limited, but in a recent 2018 report on federal funding
shortfalls, the U.S. Commission on Civil Rights reported that in Fiscal Year 2013, the IHS PRCP

1 denied an estimated 147,000 medical claims as needed by AI/AN patients—amounting to \$761
2 million in unmet need⁹; and

3
4 Whereas, Tribal Health Programs often augment PRCP funding with their own funds to increase
5 access to medical specialty care¹⁰; and

6
7 Whereas, More than 70 percent of the AI/AN population lives in Urban Areas, yet Urban Indian
8 Health Programs are not eligible to participate in PRCP, limiting access to care^{5,11}; and

9
10 Whereas, Community benefit is a legal term for expenditures made by non-profit hospitals to
11 fulfill their charitable obligations as tax-exempt health care institutions¹²; and

12
13 Whereas, In 2019, 180 California nonprofit hospitals reported a total of over \$6 billion in
14 community benefit expenditures, \$2.9 billion of which were attributed to coverage of Medicaid
15 shortfalls, and another \$861 million attributed to financial assistance for uninsured patients (63%
16 of all expenditures)¹²; and

17
18 Whereas, Community benefit dollars have the potential to increase access to comprehensive,
19 high-quality specialty care for AI/AN patients in states with large AI/AN populations, like
20 California¹²; and

21
22 Whereas, Our American Medical Association supports special allocations of community benefit
23 dollars to meet unmet health needs (H-215.961); therefore be it

24
25 RESOLVED, That our American Medical Association advocate to Congress to 1) increase
26 funding to the Indian Health Service Purchased/Referred Care Program to enable the program
27 to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served
28 by Urban Indian Health Programs (Directive to Take Action); and be it further

29
30 RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars
31 to increase access to specialty care for patients referred from Indian Health Service, Tribal, and
32 Urban Indian Health Programs. (New HOD Policy)

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

Received: 3/24/23

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RELEVANT AMA POLICY

Community Benefit Dollars for Diabetes Prevention H-215.961

1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program.
2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars.
3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients.
4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.

Citation: Res. 427, A-16;

Access to Specialty Care H-160.952

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.

Citation: (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09; Reaffirmed in lieu of Res. 815, I-13)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states

where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-23)

Introduced by: Medical Student Section

Subject: The Health Care Related Effects of Recent Changes to the US Mexico
Border

Referred to: Reference Committee B

1 Whereas, The U.S Mexico border extends 1980 miles from San Diego, California to
2 Brownsville, Texas with hundreds of thousands of undocumented immigrants entering the
3 U.S illegally every year¹; and
4

5 Whereas, On January 24th, 2017, President Trump signed the “Border Security and
6 Immigration Enforcement Improvements” Executive Order that resulted in an increase in the
7 height of the border wall from 17 to 30 feet and initiated the addition of 49 miles of new wall²;
8 and
9

10 Whereas, The Biden administration halted all border wall construction initiated by the Trump
11 administration upon taking office but has recently been approving projects along the border to
12 continue construction ³⁻⁵; and
13

14 Whereas, On March 20th, 2020, the Center for Disease Control under the Trump
15 administration issued a public health order, Title 42, a law that allows removals by the U.S.
16 government of persons who have recently been in a country where a communicable disease
17 was present, which effectively shut the border to asylum seekers⁶; and
18

19 Whereas, The US has to date expelled over 1.8 million individuals under Title 42, and the
20 border has experienced a significant increase in repeat and overall crossings at the border⁷;
21 and
22

23 Whereas, Crossing the border for many results in injuries requiring medical assistance such
24 as physical trauma, rhabdomyolysis, dehydration, and death^{8,9}; and
25

26 Whereas, Study comparing cases of fatal injuries from falls sustained when climbing the US
27 Mexico border wall determined that the implication of both lateral and vertical expansion of
28 the wall is increased severity and cost of the trauma ^{10,11}; and
29

30 Whereas, A study found that 55% of migrants crossing the border experienced moderate to
31 grave psychological suffering when screened by Doctors Without Borders¹²; and
32

33 Whereas, A study from Arizona described damage to the cranium and spine as a clinically
34 prevalent and costly result of border wall crossing that needs to be addressed to decrease
35 the detrimental impacts felt both by immigrants and surrounding health care systems ⁹; and
36

37 Whereas, One study of the San Diegan US - Mexico Border compared medical outcomes pre
38 and post changes to the border by the Trump administration and saw a greater than fivefold

1 increase in admissions, significantly increased hospital and scene mortality, as well as
2 admissions costs in 2021 which exceeded 13 million USD¹¹; and

3
4 Whereas, A study on the Rio Grande Valley of 121 undocumented immigrants who were
5 injured in their travels incurred a cost of 1.1 million USD to the healthcare system that
6 provided care for this patient population¹³; and

7
8 Whereas, One study found the majority of deaths at the US-Mexico border were highly
9 preventable¹⁴; therefore be it

10
11 RESOLVED, That our American Medical Association recognize the health-related effects and
12 humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant
13 populations and the resulting effects on the U.S. healthcare system (New HOD Policy); and
14 be it further

15
16 RESOLVED, That our AMA oppose efforts to increase the height or length of border walls
17 and fences at the US-Mexico border, and other policies that deter people from crossing the
18 border by increasing or creating risks to their health and safety. (New HOD Policy)

19
Fiscal Note: Minimal - less than \$1,000

Received: 3/31/23

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RELEVANT AMA POLICY

Financial Impact of Immigration on American Health System D-160.988

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Citation: Res. 235, A-06; Reaffirmation I-10; Reaffirmed: BOT Rep. 04, A-20;

Improving Healthcare of Hispanic Populations in the United States H-350.975

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.

(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.

(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.

(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.

(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.

(6) Promote research into effectiveness of Hispanic health education methods.

(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20;

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Citation: Res. 018, A-17;

Separation of Children From Their Caregivers at Border H-440.818

Our AMA will: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and (2) urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

Citation: Res. 253, A-18;

Addressing and Banning Nonconsensual Medical Procedures Among Migrant Women at the Border D-350.978

Our AMA: (1) condemns the performance of nonconsensual, invasive medical procedures; (2) will advocate against forced sterilizations of any kind, including against migrant women in detention facilities, and advocate for appropriate associated disciplinary action (including license revocation); and (3) will advocate for safer medical practices and protections for migrant women.

Citation: Res. 016, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits

Referred to: Reference Committee B

1 Whereas, Rape/sexual assault affected 319,950 individuals in the United States in the year
2 2020, which is a rate of 1.2 individuals per 1,000¹; and
3

4 Whereas, The estimated lifetime cost of rape is \$122,461 per victim including but not limited
5 to medical forensic examination, hospitalization/emergency department bills, sexually
6 transmitted infection testing/treatment, criminal justice costs, mental health costs such as
7 depression and/or PTSD treatment, abortion costs, and emergency contraceptive costs²; and
8

9 Whereas, With more restricted access to abortion, the financial burden to rape/sexual assault
10 victims is likely to increase as patients may now need to cross state lines, obtain a hotel/find
11 temporary housing, take days off work, or incur additional costs to receive appropriate
12 medical care³⁻⁵; and
13

14 Whereas, The mental effect of rape/sexual assault may impact how victims present to the
15 hospital, as victims may be in a vulnerable state with impaired rational thought, memory
16 consolidation, and reduced energy and/or tonic immobility due to trauma⁶; and
17

18 Whereas, Medical forensic exams, also known as rape test kits, involve a partnership
19 between the healthcare provider and the crime lab to collect any DNA evidence on the body
20 of the victim or at the scene of the crime, physical examination to look for signs of abuse, and
21 medical history taking to aid in criminal case investigation^{7,8}; and
22

23 Whereas, Rape test kits, are not financially covered by all states if the provider administering
24 the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual
25 Assault Forensic Examiner (SAFE)⁹; and
26

27 Whereas, Receiving care by SANE/SAFEs is associated with better psychological well-being
28 of survivors, increased use of STI prophylaxis and emergency contraception, and higher
29 quality evidence collection resulting in better legal outcomes¹⁰; and
30

31 Whereas, Healthcare staff not trained as SANE/SAFEs have reported discomfort providing
32 sexual assault services due to lack of knowledge about evidence collection and support
33 needs, leading to increased isolation and stigmatization of victims¹¹; and
34

35 Whereas, The speed at which medical forensic examinations must be done is between 72
36 and 96 hours after the assault has taken place, making this a time-sensitive examination¹²;
37 and

1 Whereas, While there are more than 6,000 hospitals nationally; only 800-900 SANE
2 programs have been identified in the United States⁹; and
3

4 Whereas, The Department of Justice explains that states are required to work with local
5 medical providers to inform victims of the availability of no-cost forensic exams such that a
6 victim can call their local police department or hotline/crisis center to obtain information about
7 local SANEs/SAFEs⁹; and
8

9 Whereas, Victims who do not interact with law enforcement may not know how to access no-
10 cost medical forensic examinations; and
11

12 Whereas, Groups of individuals that have historically under-reported rape and sexual assault,
13 such as African-American and Hispanic women and the LGBTQ+ community, are less likely
14 to interact with law enforcement and therefore less likely to be informed about no-cost rape
15 test kits¹³⁻¹⁵; and
16

17 Whereas, Information about the availability of SANE/SAFEs is currently limited, and existing
18 databases are only available in certain areas, are outdated, and are often missing information¹⁶;
19 and
20

21 Whereas, Creating and ensuring accessibility to a national database of Sexual Assault Nurse
22 Examiner and Sexual Assault Forensic Examiner providers would allow all victims to quickly
23 access information on where and how to receive a time-sensitive, no-cost medical forensic
24 examination; and
25

26 Whereas, Increasing accessibility to information on SANE/SAFE locations and providers
27 would allow minority and other vulnerable populations to have more equal opportunities to
28 receive no-cost medical forensic examination; therefore be it
29

30 RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual
31 Assault Survivors," by addition to read as follows:
32

33 **Sexual Assault Survivors, H-80.999**

34 1. Our AMA supports the preparation and dissemination of information
35 and best practices intended to maintain and improve the skills needed by
36 all practicing physicians involved in providing care to sexual assault
37 survivors.

38 2. Our AMA advocates for the legal protection of sexual assault survivors'
39 rights and work with state medical societies to ensure that each state
40 implements these rights, which include but are not limited to, the right to:
41 (a) receive a medical forensic examination free of charge, which includes
42 but is not limited to HIV/STD testing and treatment, pregnancy testing,
43 treatment of injuries, and collection of forensic evidence; (b) preservation
44 of a sexual assault evidence collection kit for at least the maximum
45 applicable statute of limitation; (c) notification of any intended disposal of
46 a sexual assault evidence kit with the opportunity to be granted further
47 preservation; (d) be informed of these rights and the policies governing
48 the sexual assault evidence kit; and (e) access to emergency
49 contraception information and treatment for pregnancy prevention.

- 1 3. Our AMA will collaborate with relevant stakeholders to develop
2 recommendations for implementing best practices in the treatment of
3 sexual assault survivors, including through engagement with the joint
4 working group established for this purpose under the Survivor's Bill of
5 Rights Act of 2016.
- 6 4. Our AMA will (a) advocate for increased post-pubertal patient access to
7 Sexual Assault Nurse Examiners, and other trained and qualified
8 clinicians, in the emergency department for medical forensic
9 examinations; (b) support and advocate that appropriate stakeholders,
10 such as the Health Resources and Services Administration, the United
11 States Government Accountability Office, and the Office on Violence
12 Against Women, create and implement a national database of Sexual
13 Assault Nurse Examiner and Sexual Assault Forensic Examiner
14 providers.
- 15 5. Our AMA will advocate at the state and federal level for (a) the timely
16 processing of all sexual examination kits upon patient consent; (b) timely
17 processing of "backlogged" sexual assault examination kits with patient
18 consent; and (c) additional funding to facilitate the timely testing of sexual
19 assault evidence kits. (Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-23)

Introduced by: Oklahoma
Subject: Marijuana Product Safety
Referred to: Reference Committee B

1 Whereas, Physicians prioritize patient safety, and the American Medical Association Code of
2 Medical Ethics underscores its commitment "to promote the art of medicine and the betterment
3 of public health"; and
4
5 Whereas, There are many legal implications due to the passage of state marijuana laws and the
6 associated regulations passed by State Departments of Health; and
7
8 Whereas, Current American Medical Association policy H-95.952, "Cannabis and Cannabinoid
9 Research" calls for adequate and well-controlled studies of marijuana and urges that
10 marijuana's status as a federal schedule I controlled substance be reviewed with the goal of
11 facilitating the conduct of clinical research; and
12
13 Whereas, Current AMA policy D-95.969, "Cannabis Legalization for Medicinal Use" states: Our
14 AMA (3) will develop model legislation requiring the following warning on all cannabis products
15 not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for
16 abuse. This product has not been approved by the Food and Drug Administration for preventing
17 or treating any disease process."; and
18
19 Whereas, To date, the FDA has not approved a marketing application for cannabis for the
20 treatment of any disease or condition¹; and
21
22 Whereas, The FDA has, approved one cannabis-derived drug product: Epidiolex
23 (cannabidiol)(oral solution for the treatment of seizures associated with two rare and severe
24 forms of epilepsy, Lennox-Gastaut syndrome and Dravet syndrome), and three synthetic
25 cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet
26 (nabilone)^{1,2}; and
27
28 Whereas, The FDA is aware that some companies are marketing products containing cannabis
29 and cannabis-derived compounds in ways that violate the Federal Food, Drug and Cosmetic Act
30 (FD&C Act) and that may put the health and safety of consumers at risk³; and
31
32 Whereas, The FDA is committed to protecting the public health while also taking steps to
33 improve the efficiency of regulatory pathways for the lawful marketing of appropriate cannabis
34 and cannabis-derived products³; and
35
36 Whereas, Under the drug application process, a sponsor of a nonprescription drug submits a
37 New Drug Application (NDA) or an Abbreviated New Drug Application (ANDA) to FDA for
38 approval with the sponsor not able to market the nonprescription drug until FDA approves the
39 NDA or ANDA⁴; therefore be it

- 1 RESOLVED, That our American Medical Association support the policy against marijuana use,
2 either medical or recreational, until such time scientifically valid and well-controlled clinical trials
3 are done to assess the safety and effectiveness as any new drug for medical use, prescription
4 or nonprescription (New HOD Policy); and be it further
5
6 RESOLVED, That our AMA Council on Legislation draft state model legislation for states that
7 have legalized “medical” or “recreational” marijuana that (1) prohibit dispensaries from selling
8 marijuana products if they make any misleading health information and/or therapeutic claims,
9 (2) to require dispensaries to include a hazardous warning on all marijuana product labels
10 similar to tobacco and alcohol warnings and (3) ban the advertising of marijuana dispensaries
11 and marijuana products in places that children frequent. (Directive to Take Action)

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

Received: 4/20/23

REFERENCES

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3. <https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd>
4. <https://www.fda.gov/drugs/special-features/how-fda-strives-ensure-safety-otc-products>

RELEVANT AMA POLICY

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Reaffirmation: A-22;

CBD Oil Use and the Marketing of CBD Oil H-95.911

Our AMA supports: (1) banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and (2) legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims. Citation: Res. 505, A-22;

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-23)

Introduced by: Senior Physicians Section
Subject: Telemedicine Services and Health Equity
Referred to: Reference Committee B

1 Whereas, Seniors with complex health conditions increasingly rely on telemedicine to receive
2 specialized care from out-of-state expert physicians; and
3
4 Whereas, Telemedicine reciprocity is limited to only 36 states, and some state boards prohibit
5 telemedicine across state lines except in emergencies; and
6
7 Whereas, The AMA Principles of Medical Ethics addresses provision of appropriate patient care
8 as well as activities contributing to the betterment of public health for all people¹; and
9
10 Whereas, Telemedicine evaluation and management has been approved at parity with in-
11 person professional visits and accepted positively by the majority of patients and doctors²; and
12
13 Whereas, Access to virtual care positively affects underserved populations, rural seniors,
14 patients who suffer from chronic conditions, and patients with mobility or transportation issues;
15 and
16
17 Whereas, Nationwide telemedicine is increasingly accepted as optimal care under many
18 circumstances, and revised state licensure could improve access to care; and
19
20 Whereas, Extension of telehealth coverage and payment parity may expire or be threatened as
21 exemplified by national and some state insurance/support programs; and
22
23 Whereas, Some government and other payers require once-a-year in-person physician
24 encounters besides usual telemedicine visits; therefore be it
25
26 RESOLVED, That our American Medical Association advocate for preservation of the physician
27 telemedicine waiver and reimbursement at parity with in-person visits beyond December 31,
28 2024 (Directive to Take Action); and be it further
29
30 RESOLVED, That our AMA encourage research to determine the scope and circumstances of
31 telehealth improved health outcomes, especially for underserved populations and seniors with
32 complex health conditions that includes how best to ensure patients have the training in the use
33 of technology needed to maximize its benefits. (New HOD Policy)
34

Fiscal Note:
First Resolved: Modest - between \$1,000 - \$5,000
Second Resolved: Minimal - less than \$1,000

Received: 4/26/23

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1. American Medical Association, *Code of Medical Ethics*. Chicago, IL: American Medical Association, 2022:1. Retrieved 03/13/23 from <https://code-medical-ethics.ama-assn.org/principles>
2. Henry, T.A. "Patients, Doctors Like Telehealth. Here's What Should Come Next." AMA Website, 2021. Retrieved 03/13/23 from <https://www.ama-assn.org/practice-management/digital/patients-doctors-telehealth-here-s-what-should-come-next>

RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CSAPH Rep. 2, A-22;

Addressing Equity in Telehealth H-480.937

Our AMA:

- (1) recognizes access to broadband internet as a social determinant of health;
- (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
- (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
- (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
- (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
- (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
- (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
- (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
- (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Citation: CMS Rep. 7, A-21; Reaffirmation: A-22;

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21; Reaffirmed: Res. 239, A-22; Reaffirmation: A-22;

The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

(a) exemption from such a licensure requirement for physician-to-physician consultations;

(b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;

(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and

(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09;

Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12;

Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14;

Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21; Reaffirmed:

Res. 239, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-23)

Introduced by: Senior Physicians Section

Subject: Advocacy and Action for a Sustainable Medical Care System

Referred to: Reference Committee B

1 Whereas, Medicare has given financial raises to hospitals, ambulatory care facilities and
2 pharmaceutical companies while physicians and their practices have also experienced rising
3 costs for personnel, supplies, rent and other expenses without similar raises; and
4

5 Whereas, Many senior physicians in private practice are financially vulnerable and are
6 contemplating retiring earlier than expected due to inadequate revenue and refusal of Congress
7 to adjust Medicare rates consistent with rising costs and inflation; and
8

9 Whereas, Our American Medical Association via the AMA Recovery Plan for America's
10 Physicians, and 120 state medical and national specialty societies, have endorsed ten principles
11 to guide Congress in an overhaul to remedy the financial instabilities affecting physician
12 practices in an unsustainable six-year payment freeze¹; and
13

14 Whereas, Payments to physicians are the only economic segment of the US health care system
15 without inflation-based updates, a 22% lag when adjusted for inflation over the past 20 years;
16 and
17

18 Whereas, Small independent practices are more cost-efficient care centers than larger or
19 institutional practices, so loss of independent practices will ultimately cost more,^{2,3} reduce
20 competition, and diminish access to care^{4,5}; therefore be it
21

22 RESOLVED, That our American Medical Association continue to strongly advocate for fair
23 reimbursement of all segments of health care, particularly physicians, to undo inadequate
24 payment relative to inflation (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician
27 payment at least on an annual basis in order to match that given to hospitals, extended and
28 ambulatory care facilities, medical device and pharmaceutical companies for rising practice
29 costs and inflation. (Directive to Take Action)
30

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

Received: 4/26/23

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RELEVANT AMA POLICY

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

Citation: Res. 212, I-21; Reaffirmed: Res. 240, A-22;

The Site-of-Service Differential D-330.902

1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.
2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.
4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.
5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.
7. Our AMA will consider disseminating the resulting educational materials and graphics.

Citation: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Appended: Res. 826, I-22;

Federal EMR and Electronic Prescribing Incentive Program H-478.991

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize

or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

Citation: (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)

Accurate Reporting of Physician Charges H-380.991

The AMA believes that, since actual payment from Medicare and private insurers is substantially lower than submitted charges, it is misleading and inappropriate to draw inferences about physician fee inflation from submitted charge data.

Citation: BOT Rep. 1, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Legislative and Regulatory Efforts Against Fertility Fraud

Referred to: Reference Committee B

1 Whereas, Illicit insemination, or fertility fraud, is defined as the failure on the part of a fertility
2 doctor to obtain consent from a patient before inseminating her with his own sperm normally
3 in the context of patients using assisted reproductive technology¹; and
4

5 Whereas, The results of a 1987 survey conducted showed that as many of 2% of fertility
6 doctors polled had used their own sperm to inseminate their patients²; and
7

8 Whereas, Over the past several years, more than 50 fertility doctors in the United States
9 have been accused of fertility fraud and nearly all of the physicians who have been accused
10 were discovered as a result of DNA tests taken by their offspring³; and
11

12 Whereas, Physicians' inseminations of nonconsenting and unaware patients represent a
13 gross trespass against all standards of modern practice⁴; and
14

15 Whereas, Engaging in illicit insemination exploits patients' ignorance of circumstance, trust,
16 intense desire to conceive, and vulnerability and breaches other ethical obligations, including
17 the duty to disclose all relevant medical information to patients and to deal honestly with
18 them, robbing them of their decision-making autonomy⁴; and
19

20 Whereas, Former patients of these physicians speak of feeling violated and assaulted, their
21 personal dignity and bodily integrity trampled, their family plans routed, and their trust
22 broken⁵; and
23

24 Whereas, Illicit insemination is a violation of the ethical principle of respecting individual
25 autonomy to make an informed decision regarding the nature of one's health⁵; and
26

27 Whereas, Illicit insemination is a violation of the ethical principle and physicians' responsibility
28 to truth-telling^{5,6}; and
29

30 Whereas, These ethical, medical, and psychological issues patients and their children face
31 as a result of physician actions directly contradicts the medical ethics principle of
32 nonmaleficence⁷; and
33

34 Whereas, Only four states specifically penalize physicians for inseminating their own sperm
35 into patients without express consent and there are no federal penalties^{2,8}; and
36

37 Whereas, In Texas, Senate Bill 1259 classified illicit insemination as a form of sexual
38 assault⁹; and

1 Whereas, Indiana lawmakers introduced Senate Bill 174, making it legal for victims of fertility
2 fraud to pursue legal action against physicians who commit acts of fertility fraud¹⁰; and
3

4 Whereas, Arizona lawmakers approved Senate Bill 1237 in 2021, giving victims and children
5 conceived from illicit insemination the opportunity to pursue civil damages against the
6 physician committing fertility fraud¹¹; and
7

8 Whereas, Utah House Bill 192 states that healthcare providers may not knowingly use their
9 own gametes during assisted reproductive treatment without the patient's written consent,
10 otherwise punishable as a third degree felony¹²; and
11

12 Whereas, A lack of laws regarding illicit insemination in the majority of states requires people
13 and families affected to seek legal action through application of existing criminal laws, such
14 as those written for criminal deception, sexual battery, or rape, which do not fully apply to or
15 encompass the actions conducted^{5,13}; and
16

17 Whereas, The use of applicable criminal laws that were written without consideration for illicit
18 insemination may result in relevant cases being a poor fit for existing law, expiring past the
19 statutes of limitation, or lacking evidence due to temporal constraints^{5,13}; and
20

21 Whereas, The rise of consumer genetic testing is growing in popularity with estimates of 26
22 million testing kits bought in 2019 and an annual growth rate of 12.25%^{14,15}; and
23

24 Whereas, Hundreds of people who have been fathered by non-consensual insemination have
25 discovered this information through consumer genetic testing^{16,17}; and
26

27 Whereas, A number of countries already have legislation that restrict the number of
28 conceptions by an individual sperm donor in order to prevent unintentional consanguinity⁷;
29 and
30

31 Whereas, The American Society of Reproductive Medicine recommends restricting
32 conceptions by individual donors to 25 births per population of 800,000 to avoid unintentional
33 consanguinity⁷; and
34

35 Whereas, Without measures to prevent illicit insemination by physicians, increased risk of
36 consanguinity in communities can pose a significant threat to public health and lead to
37 medical, psychological and ethical issues patients and their children must face¹⁸; therefore be
38 it
39

40 RESOLVED, That our American Medical Association oppose physicians using their own
41 sperm to artificially inseminate patients without proper explicit and informed patient consent,
42 otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further
43

44 RESOLVED, That our AMA support legislative and regulatory efforts to protect patients
45 from physicians and healthcare practitioners who inseminate their own sperm into patients
46 without their consent. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients.

Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.

- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Issued: 2016

E-4.2.3 Therapeutic Donor Insemination

Therapeutic donor insemination using sperm from a woman's partner or a third-party donor can enable a woman or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents).

However, the procedure also raises ethical considerations about safety for the woman and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.

Physicians who choose to provide artificial insemination should:

- (a) Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient's marital status.
- (b) Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate):
 - (i) about the risks, benefits, likelihood of success, and costs of the intervention;
 - (ii) about the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination;
 - (iii) about the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event the donor dies;
 - (iv) that state law will govern the status, obligations, and rights of the sperm donor, known or anonymous, in relation to a resulting child.
- (c) When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
 - (i) about the need to test donated semen for infectious disease agents and genetic disorders;
 - (ii) whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder;
 - (iii) that state law will govern the status, obligations, and rights of the donor in relation to a resulting child.
- (d) Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision.
- (e) Provide sex selection of sperm only for purposes of avoiding a sex-linked inheritable disorder. Physicians should not participate in sex selection of sperm for reasons of gender preference.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Foster Care Services for Children

Referred to: Reference Committee B

1 Whereas, The Family First Prevention Services Act (FFPSA) was signed into law in February
2 2018 with a goal within the child welfare system on keeping children safely with their families to
3 avoid the trauma that results when children are placed in out-of-home care; and
4

5 Whereas, The FFPSA provides at risk families with access to mental health services, substance
6 use treatment, and/or parenting skills courses; and
7

8 Whereas, The FFPSA created the Title IV-E Prevention Services Clearinghouse which
9 maintains a continuously updated and comprehensive list of evaluated and tested prevention
10 services and programs for families at risk for entry into the child welfare system; and
11

12 Whereas, States are allowed under FFPSA to use Title IV-E funds toward services which can
13 help prevent family progression into the child welfare system and/or removal of a child from the
14 family unit and must submit a 5-year Title IV-E prevention plan for approval prior to drawing
15 down this funding; and
16

17 Whereas, State, territory, and tribe implementation of this Act has been varied and additional
18 state funding is required for administration of the Act in addition to adoption of improved foster
19 care placement avoiding residential placement where possible; therefore be it
20

21 RESOLVED, That our American Medical Association encourage and support state, territory, and
22 tribe activities to implement changes to the child welfare system directed toward safely keeping
23 children with their families when appropriate (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA support federal and state efforts to expand access to evidence -
26 based services which can prevent foster care and keep families safely together, including
27 mental health, substance use disorder treatment, and in-home parent skills-based services
28 (Directive to Take Action); and be it further
29

30 RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and
31 family foster care placement and state efforts to eliminate the use of non-therapeutic congregate
32 foster care placement (New HOD Policy); and be it further
33

34 RESOLVED, That our AMA support both federal and state funding for improvements to the child
35 welfare system which minimize harm to the child and help provide additional services to families
36 that will safely prevent child separation from the family (New HOD Policy); and be it further
37

38 RESOLVED, That our AMA urge the development and promotion of a continuously updated and
39 comprehensive list of evaluated and tested prevention services and programs for families at risk
40 for entry into the child welfare system. (New HOD Policy)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Society of Addiction Medicine

Subject: Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools

Referred to: Reference Committee B

- 1 Whereas, Our American Medical Association with other interested organizations declare the
- 2 opioid epidemic as one of the many factors within the National Child Mental Health Crisis; and
- 3
- 4 Whereas, Drug overdose deaths in youths from ages 10 to 19 years of age increased 109%
- 5 from 2019-2021; and
- 6
- 7 Whereas, There is increased access of illicit manufactured fentanyl (IMF) pills associated with
- 8 higher risk of adolescent overdose, with IMF deaths increasing 182% from 2019-2021; and
- 9
- 10 Whereas, The increased morbidity and mortality of adolescent substance use is a national
- 11 crisis; and
- 12
- 13 Whereas, Naloxone is a life-saving medication that can reverse an overdose from opioids; and
- 14
- 15 Whereas, Opioid overdose reversal must be immediate as opioid overdose can quickly result in
- 16 death; and
- 17
- 18 Whereas, Naloxone is a safe medicine and only reverses overdoses in people with opioids in
- 19 their systems; and
- 20
- 21 Whereas, Our AMA supports legislative, regulatory, and national advocacy efforts to increase
- 22 access to affordable naloxone, including but not limited to collaborative practice agreements
- 23 with pharmacists and standing orders for pharmacies and, where permitted by law, community-
- 24 based organizations, law enforcement agencies, correctional settings, schools, and other
- 25 locations that do not restrict the route of administration for naloxone delivery; and
- 26
- 27 Whereas, Our AMA supports the widespread implementation of easily accessible Naloxone
- 28 rescue stations (public availability of Naloxone through wall-mounted display/storage units that
- 29 also include instructions) throughout the country following distribution and legislative edicts
- 30 similar to those for Automated External Defibrillators; and
- 31
- 32 Whereas, All 50 states and the District of Columbia have enacted laws permitting pharmacy-
- 33 based naloxone dispensing; and
- 34
- 35 Whereas, Most states have enacted laws that provide laypersons with civil and criminal
- 36 immunity for good faith administration of naloxone; and

1 Whereas, Roughly half of US states have statutory language regarding access to naloxone in
2 schools; therefore be it

3
4 RESOLVED, That our American Medical Association encourage states, including communities
5 and school districts therein, to adopt legislative and regulatory policies that allow schools to
6 make naloxone readily accessible to school staff, teachers, and students to prevent opioid
7 overdose deaths on school campuses (New HOD Policy); and be it further

8
9 RESOLVED, That our AMA encourage states, including communities and school districts
10 therein, to eliminate barriers that preclude students from carrying naloxone in school. (New
11 HOD Policy)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-23)

Introduced by: Mississippi

Subject: Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners

Referred to: Reference Committee B

- 1 Whereas, “Direct supervision of emergency services” refers to an individual actively practicing
2 clinical medicine in the emergency department and overseeing all medical decisions in the
3 emergency department at the point of care¹; and
4
5 Whereas, Direct supervision of emergency care is distinct from medical direction; and
6
7 Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care²; and
8
9 Whereas, Nursing and medical leaders strongly recommend that, because of variations in
10 training, licensure, and certification, nurse practitioners should not work alone in emergency
11 departments²⁻⁴; and
12
13 Whereas, Centers for Medicare & Medicaid Services (CMS) provides clear regulations on the
14 direct supervision of emergency care in hospitals¹, and
15
16 Whereas, In the conditions of participation, CMS requires that for a hospital to provide
17 emergency care, all emergency departments must have direct supervision by a qualified
18 member of medical staff present in the hospital at all hours emergency services are provided¹;
19 and
20
21 Whereas, “Direct supervision for emergency services” is defined as being physically in the
22 hospital and not telemedicine¹; and
23
24 Whereas, The word “must” indicates without exception; and
25
26 Whereas, The words “qualified member” are clearly proscribed by the American College of
27 Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)^{2,3};
28 and
29
30 Whereas, While the words “medical staff,” according to CMS, may include physicians, nurse
31 practitioners, and physicians assistants¹, there is a clear requirement for additional specialized
32 training; and
33
34 Whereas, it is the responsibility of the national organizations of emergency medicine physicians
35 ACEP and AAEM to set standards for the practice of emergency medicine^{3,4}; and

1 Whereas, ACEP and AAEM determine standards for the practice of emergency medicine and
2 explicitly set the standard that nurse practitioners are unqualified to directly supervise medical
3 care (i.e. work alone) in emergency departments^{2,3}; and
4

5 Whereas, When a nurse practitioner directly supervises the emergency department (i.e. works
6 alone), they are in violation of CMS regulations, and
7

8 Whereas, The risk of nurse practitioners directly supervising emergency care in emergency
9 departments puts patients at risk of misdiagnosis, incorrect treatment, delay in care, or
10 inadequate care when time-sensitive diseases present²⁻⁴; and
11

12 Whereas, A waiver for telemedicine can mitigate staffing shortages, but it remains a temporary
13 solution and does not change the CMS regulation or standards defined by AAEM or ACEP⁵; and
14

15 Whereas, The American Medical Association acknowledges that it cannot directly hold
16 regulatory bodies accountable, but will advocate for the enforcement of CMS regulations and
17 the adoption of standards set by national organizations of emergency medicine physicians;
18 therefore be it
19

20 RESOLVED, That our American Medical Association, in accordance with Centers for Medicare
21 & Medicaid Services (CMS) Regulations and standards of practice for emergency medicine as
22 defined by American College of Emergency Physicians and American Association of
23 Emergency Medicine, advocate for the enforcement of CMS regulations and the adoption of
24 standards set by national organizations of emergency medicine physicians, and hold
25 accountable hospital systems, staffing organizations, medical staff groups, and individual
26 physicians supporting systems of care that promote direct supervision of emergency
27 departments by nurse practitioners. (Directive to Take Action)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-23)

Introduced by: Mississippi

Subject: Repealing the Ban on Physician-Owned Hospitals

Referred to: Reference Committee B

- 1 Whereas, The COVID-19 pandemic has highlighted the importance of physician leadership in
2 healthcare and the critical need for innovation and flexibility during times of crisis; and
3
4 Whereas, Physician-owned hospitals (POHs) often specialize in specific areas of medicine,
5 leading to better outcomes for patients and promoting innovation in healthcare delivery; and
6
7 Whereas, Physician ownership of hospitals can foster innovation and improve competition in the
8 healthcare market, which could help to reduce healthcare costs and improve access to care,
9 particularly in underserved areas; and
10
11 Whereas, There are concerns that physician-owned hospitals may be more likely to engage in
12 self-referral or overutilization of services, which could lead to higher costs and lower quality of
13 care; and
14
15 Whereas, Safeguards and regulations can be put in place to ensure that physician-owned
16 hospitals are operating in the best interests of patients; and
17
18 Whereas, Physician leadership is critical in healthcare, particularly during times of crisis, such
19 as the COVID-19 pandemic; and
20
21 Whereas, Restrictions on physician ownership of hospitals may limit access to quality care for
22 patients in underserved areas; and
23
24 Whereas, The American Medical Association has a longstanding policy of supporting the role of
25 physicians in healthcare leadership and advocating for policies that promote physician
26 ownership of healthcare facilities; and
27
28 Whereas, It is critical to ensure that physicians are able to provide the highest quality care and
29 make decisions based solely on the best interests of their patients; and
30
31 Whereas, Allowing physicians to have ownership in hospitals can provide incentives for quality
32 improvement, cost control, and greater coordination of care, leading to better patient outcomes
33 and satisfaction; and
34
35 Whereas, The Affordable Care Act and other healthcare policy reforms have emphasized the
36 importance of value-based care and alternative payment models, which align with the goals of
37 POHs and their emphasis on quality, efficiency, and cost-effectiveness; and

1 Whereas, Physician ownership of hospitals is common in many other countries, including
2 Canada, Germany, and the United Kingdom, and has not been associated with negative
3 consequences for patient care or healthcare costs; and
4

5 Whereas, POHs have played a critical role in providing essential services during natural
6 disasters and pandemics, as demonstrated by their response to Hurricanes Katrina and Rita in
7 2005 and the COVID-19 pandemic in 2020; and
8

9 Whereas, POHs provide valuable opportunities for physician training and education, research,
10 and innovation; and
11

12 Whereas, Physicians have a unique perspective and expertise that can be valuable in hospital
13 governance and decision-making, and can help to ensure that the patient's best interests are
14 always at the forefront of hospital operations; therefore be it
15

16 RESOLVED, That our American Medical Association advocate for policies that alleviate any
17 restriction upon physicians from owning, constructing, and/or expanding any hospital facility
18 type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment
19 of physicians dedication to patient care (Directive to Take Action); and be it further
20

21 RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to
22 ensure that physician-owned hospitals are operating in the best interests of patients (Directive
23 to Take Action); and be it further
24

25 RESOLVED, That our AMA encourage further study and research into the benefits and
26 drawbacks of physician-owned hospitals and their impact on patient care, as well as the
27 potential impact of regulatory safeguards to ensure transparency and accountability in
28 physician-owned hospitals (New HOD Policy); and be it further
29

30 RESOLVED, That our AMA work with policymakers to develop regulations that promote
31 transparency and accountability in physician-owned hospitals, and protect against any potential
32 conflicts of interest, while also fostering competition and innovation in the healthcare market
33 (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA continue to support physician leadership in healthcare and
36 advocate for policies that enable physicians to provide the highest quality care to their patients,
37 including policies that remove unnecessary barriers to physician ownership of hospitals
38 (Directive to Take Action); and be it further
39

40 RESOLVED, That our AMA work to educate its members and the public on the potential
41 benefits of physician ownership of hospitals and the need for policies that support such
42 ownership (Directive to Take Action); and be it further
43

44 RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations,
45 patient advocacy groups, and government agencies, to develop and promote policies that
46 support physician ownership of hospitals (Directive to Take Action); and be it further
47

48 RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the
49 progress made in implementing these resolutions, with recommendations for future action as
50 appropriate. (Directive to Take Action)

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

Received: 5/2/23

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2. (2021). AMA Health Care Advocacy Agenda. Retrieved from <https://www.ama-assn.org>

RELEVANT AMA POLICY

Hospital Consolidation H-215.960

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Citation: CMS Rep. 07, A-19; Reaffirmation I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire;
Rhode Island; Vermont; Maryland; American College of Radiation Oncology;
American Society for Radiation Oncology; American Society of Clinical
Oncology; Association of University Radiologists

Subject: Coverage of Routine Costs in Clinical Trials by Medicare Advantage
Organizations

Referred to: Reference Committee B

1 Whereas, Our American Medical Association is a powerful advocate for clinical research; and

2
3 Whereas, Our AMA believes it is an inherent obligation of managed care organizations to invest
4 in broad-based clinical research (AMA policy H-460.930, "Importance of Clinical Research");
5 and

6
7 Whereas, Our AMA advocates that the Centers for Medicare and Medicaid Services (CMS)
8 regulate Medicare Advantage Plans to assure the same treatment and authorization guidelines
9 are followed for both fee-for-service Medicare and Medicare Advantage patients (AMA policy D-
10 285.959, "Prevent Medicare Advantage Plans from Limiting Care"); and

11
12 Whereas, Our AMA supports that Medicare Advantage plans, at a minimum, must provide
13 enrollees with coverage for all Part A and Part B original Medicare services, if the enrollee is
14 entitled to benefits under both parts (AMA policy H-330.878, "Medicare Advantage Policies");
15 and

16
17 Whereas, In contrast, current Medicare policy states, "For clinical trials covered under the
18 Clinical Trials National Coverage Determination 310.1, original Medicare covers the routine
19 costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA
20 [Medicare Advantage] plans... [Emphasis added.]" (Medicare Managed Care Manual, Chapter
21 4, Section 10.7.1); and

22
23 Whereas, Current Medicare policy only holds that the Medicare Advantage Organization (MAO)
24 is responsible for paying the enrollee the cost-sharing portion that was incurred with the original
25 Medicare coverage for qualified clinical trial items (paragraph 3 of Section 10.7.1); and

26
27 Whereas, For the enrollee to receive reimbursement from the MAO for this cost-sharing portion,
28 current Medicare policy states, "To be eligible for reimbursement, an enrollee must notify their
29 plan that the enrollee received a qualified clinical trial service and provide documentation of the
30 cost-sharing incurred, as a provider bill" (paragraph 4 of section 10.7.1); and

31
32 Whereas, This means that a Medicare Advantage enrollee who enters a qualified clinical trial is
33 obligated to pay the cost-sharing portion of their standard-of-care services, and then to seek
34 reimbursement from the MAO, even though the enrollee would otherwise never have been billed
35 by the MAO for such standard services, including the cost-sharing portion; and

36

1 Whereas, The cost-sharing portion of standard services for patients enrolling on clinical trials
2 (trials that address critical questions in oncology, heart disease, and a host of other serious
3 conditions) can amount to tens of thousands of dollars across months of treatment for a single
4 patient; and

5
6 Whereas, These policies annually affect many thousands of patients enrolling on large-scale
7 clinical trials (including many funded by NIH and its individual Institutes); and

8
9 Whereas, These policies punish public-spirited patients who enter clinical trials that will provide
10 future generations with better medical treatments and improved health outcomes, even though
11 that individual has no rational expectation of benefit, given the clinical equipoise inherent in a
12 clinical trial; and

13
14 Whereas, These policies create a profound financial disincentive for patients to enter clinical
15 trials, who thereby incur many thousands of dollars in liabilities in exchange only for the promise
16 of potential future reimbursement, making trial enrollment very unattractive; and

17
18 Whereas, Most Medicare Advantage patients will not enroll in clinical trials if they are informed
19 of these financial liabilities; and

20
21 Whereas, Such policies effectively provide the MAO these sums free-of-charge for many
22 months, even though the MAO ultimately will be liable to pay these sums – in short, a “loan”
23 from the enrollee to the MAO; and

24
25 Whereas, A recent inquiry across member organizations of the Association of American Cancer
26 Institutes (AACI) identified numerous institutions across the country that reported increasing
27 difficulties with billing and reimbursement for their MAO patients; and

28
29 Whereas, At least one of these institutions (namely, Dartmouth Cancer Center) has incurred
30 significant costs to employ additional financial services staff to advise and support patients who
31 are wrestling with these payment difficulties, a fact that vividly demonstrates the needs of these
32 vulnerable, public-spirited patients and the demands on institutions attempting to support them;
33 and

34
35 Whereas, Such individual institutional interventions can only serve as temporary stopgaps and
36 cannot serve as long-term solutions to this issue, inasmuch as they create unsustainable costs
37 at the single institutional level and would engender massive expenditures if implemented across
38 larger systems and disease types; therefore be it

39
40 RESOLVED, That our American Medical Association advocate that the Centers for Medicare
41 and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine
42 costs for services that are provided as part of clinical trials covered under the Clinical Trials
43 National Coverage Determination 310.1, just as the MAO would have been required to do so
44 had the patient not enrolled in the qualified clinical trial. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Importance of Clinical Research H-460.930

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA encourages and supports development of community and practice-based clinical research networks.

Citation: CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18;

Prevent Medicare Advantage Plans from Limiting Care D-285.959

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

Citation: Res. 706, A-21;

Medicare Advantage Policies H-330.878

1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.

2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Citation: Res. 116, A-17; Reaffirmation: I-18; Appended: Res. 809, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-23)

Introduced by: Pennsylvania

Subject: In Support for Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

Referred to: Reference Committee B

1 Whereas, The Center for Disease Control and Prevention (CDC) reports that over the past 12
2 months alone, 100,000 Americans have died from opioid-related overdoses¹; and

3
4 Whereas, The medical community recognizes Opioid Use Disorder (OUD) as a condition
5 necessitating treatment and comprehensive preventative measures to curtail the harms
6 associated with it³; and

7
8 Whereas, The presence of highly potent synthetic opioid adulterants, namely fentanyl and its
9 analogues⁴, in the illicit drug market has fueled a national public health crisis and increase in
10 opioid overdoses⁵; and

11
12 Whereas, The US Drug Enforcement Administration’s 2020 National Drug Threat Assessment
13 reports an increasing number of deaths attributable to fentanyl contamination of the illicit drug
14 supply (“lacing”) in 38 states⁶; and

15
16 Whereas, In 2021, the United Nations Global Commission on Drug Policy called for the
17 inclusion of drug checking services, such as Fentanyl Test Strips (FTS), as an additional harm-
18 reduction tool in combating overdoses⁸; and

19
20 Whereas, A study of self-reported drug-using adults in Rhode Island demonstrated that
21 approximately 50% of individuals who used FTS and whose drug tested positive for fentanyl
22 took steps to reduce their risk of overdose, including decreasing their dose, not using alone,
23 having Naloxone nearby, or discarding the supply¹⁰; and

24
25 Whereas, A multi-site analysis concluded that FTS, compared to other portable drug checking
26 technologies, have the lowest detection threshold and highest specificity for fentanyl, detecting
27 over 10-fentanyl analogs^{11,12}; and

28
29 Whereas, The CDC and the Substance Abuse and Mental Health Services Administration
30 approved the use of federal funding for the purchase and distribution of FTS¹³; and

31
32 Whereas, FTS remain classified as drug paraphernalia in a majority of states under the
33 Controlled Substance, Drug, Device and Cosmetic Act¹⁴—which is a hindrance to their
34 widespread adoption, distribution, and acceptance; and

35
36 Whereas, A 2021 correspondence¹⁵ between the American Medical Association and the White
37 House’s Acting Director of the Office of National Drug Control Policy, as well as a 2021 JAMA
38 Network report, shared this concern regarding the impact of FTS’s legality on their
39 accessibility¹⁶; therefore be it

1 RESOLVED, That our American Medical Association amend AMA Policy D-95.987, "Prevention
2 of Drug-Related Overdose," by addition to read as follows:
3

- 4 1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and
5 drug-related overdoses and death places on patients and society alike and reaffirms its
6 support for the compassionate treatment of patients with a SUD and people who use
7 drugs; (b) urges that community-based programs offering naloxone and other opioid
8 overdose and drug safety and prevention services continue to be implemented in order
9 to further develop best practices in this area; (c) encourages the education of health care
10 workers and people who use drugs about the use of naloxone and other harm reduction
11 measures in preventing opioid and other drug-related overdose fatalities; and (d) will
12 continue to monitor the progress of such initiatives and respond as appropriate.
- 13 2. Our AMA will: advocate for the removal of FTS from the legal definition of drug
14 paraphernalia.
- 15 3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their
16 caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the
17 continued study and implementation of appropriate treatments and risk mitigation
18 methods for patients at risk for a drug-related overdose.
- 19 4. Our AMA will support the development and implementation of appropriate education
20 programs for persons receiving treatment for a SUD or in recovery from a SUD and their
21 friends/families that address harm reduction measures.
- 22 5. Our AMA will advocate for and encourage state and county medical societies to
23 advocate for harm reduction policies that provide civil and criminal immunity for the
24 possession, distribution, and use of "drug paraphernalia" designed for harm reduction
25 from drug use, including but not limited to drug contamination testing and injection drug
26 preparation, use, and disposal supplies.
- 27 6. Our AMA will implement an education program for patients with substance use disorder
28 and their family/caregivers to increase understanding of the increased risk of adverse
29 outcomes associated with having a substance use disorder and a serious respiratory
30 illness such as COVID-19.
- 31 7. Our AMA supports efforts to increase access to fentanyl test strips and other drug
32 checking supplies for purposes of harm reduction by supporting both legalization of FTS
33 use by patients, as well as training in FTS use, by pertinent professionals. (Modify
34 Current HOD Policy)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-23)

Introduced by: Pennsylvania

Subject: Physician Ownership of Hospital Blocked by the ACA

Referred to: Reference Committee B

- 1 Whereas, The Affordable Care Act (ACA) has prohibited physician ownership of new hospitals
2 as well as placing onerous restrictions on previously existing physician-owned facilities; and
3
4 Whereas, Consolidation in the healthcare space has lowered the number of hospitals available
5 to treat patients; and
6
7 Whereas, Lack of competition results in higher prices, fewer choices, and potentially longer wait
8 times for Americans seeking inpatient care; and
9
10 Whereas, Data shows that physician-owned specialty hospitals and surgical centers have
11 superior safety and quality metrics as well as overall outcomes compared to similar non-
12 physician owned entities; and
13
14 Whereas, The ban on physician ownership of new hospitals both harms patient access to care
15 and unfairly restricts physician participation in potential solutions to the multiple healthcare
16 crises facing our population; therefore be it
17
18 RESOLVED, That our American Medical Association explore and report back to the House of
19 Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to
20 the ban on physician ownership of new hospitals under the relevant provisions of the Affordable
21 Care Act. (Directive to Take Action)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-23)

Introduced by: The Endocrine Society, American Association of Clinical Endocrinology,
American Society for Reproductive Medicine

Subject: Protecting Access to Gender Affirming Care

Referred to: Reference Committee B

1 Whereas, Gender-affirming care is defined by the United States Department of Health and
2 Human Services as a “supportive form of healthcare” consisting of “an array of services that
3 may include medical, surgical, mental health, and non-medical services for transgender and
4 nonbinary people”¹; and
5

6 Whereas, Gender incongruence refers to when the gender identity of a person does not align
7 with the gender assigned at birth, and gender dysphoria is a condition in which a person with
8 gender incongruence experiences significant burden associated with DSM classification; people
9 experiencing gender incongruence and/or gender dysphoria may or may not identify as
10 transgender or non-binary²; and
11

12 Whereas, World Professional Association for Transgender Health (WPATH) establishes
13 standards of care for children and adolescents that allow for puberty suppressing hormones (a
14 fully reversible intervention) at onset of puberty, hormone replacement therapy for adolescents
15 who have begun the physical changes of puberty, and limited gender-affirming surgical
16 treatments in some cases³; and
17

18 Whereas, The Endocrine Society recommends that gender-affirming hormone therapy, which is
19 partially reversible, be offered to adolescents who continue to demonstrate gender
20 incongruence with pubertal hormone suppression, and who demonstrate the ability to provide
21 informed consent, usually beginning at 16 years old⁴; and
22

23 Whereas, The American Academy of Pediatrics (AAP) states that gender-affirming medical care
24 for gender-diverse and transgender adolescents may include puberty blockers during puberty
25 and/or cross-sex hormone therapy from early adolescence onward⁵; and
26

27 Whereas, Data from the AAP showed that 50% of transgender male teens, 30% of transgender
28 female teens, and 42% of nonbinary youth reported attempting suicide in their lifetime⁶; and
29

30 Whereas, Studies of transgender and non-binary youth and adults show that those receiving
31 gender-affirming hormone therapy or puberty blockers have decreased anxiety and depression
32 symptoms, reduced suicidality, and increased appearance congruence, positive affect, and life
33 satisfaction⁷⁻¹⁰; and
34

35 Whereas, The ACLU is currently tracking several hundred anti-LGBTQ bills in the United States,
36 many of which are targeted towards transgender youth and directly outline, ban, and/or
37 criminalize gender-affirming medical and surgical procedures, name them as child abuse,
38 prohibit physicians from providing said procedures by subjecting them to felony charges and/or

1 other legal repercussions, and/or deny public funding or insurance coverage for their
2 provision^{11,12}; and
3

4 Whereas, As of April 2023, laws that prohibit or restrict access to gender-affirming care for
5 transgender youth have already passed at the state-level in twelve states, and Florida has
6 banned gender-affirming care for minors via votes of the Florida Board of Medicine and Florida
7 Board of Osteopathic Medicine¹²⁻¹⁴; and
8

9 Whereas, Some proposed bills extend restrictions on gender-affirming care to include
10 transgender young adults up to 21-26 years old in addition to transgender minors and/or
11 effectively ban gender affirming care for all adults by restricting reimbursement for providers or
12 prohibiting coverage with public funds¹⁵⁻¹⁷; and
13

14 Whereas, The Human Rights Campaign reports that over half of transgender youth, ages 13 to
15 17, have lost or are at risk of losing access to medically necessary gender-affirming care in their
16 state¹⁸; and
17

18 Whereas, Surveys of transgender and gender-diverse youth and parents of these youth show
19 that debates about the rights of transgender people and proposed legislation restricting access
20 to gender-affirming care have negatively impacted mental health and led to increased
21 discrimination for youth^{19,20}; and
22

23 Whereas, Several states, including Minnesota, Illinois, New Mexico, Vermont, and New Jersey,
24 have enacted bills or policies that protect physicians and patients providing and receiving
25 gender-affirming care and/or declared themselves as “safe haven” states, and several other
26 states have similar bills being introduced^{21,22}; and
27

28 Whereas, In 2022, Boston Children’s Hospital and Akron Children’s Hospital received threats of
29 violence due to the fact that these hospitals provide gender-affirming care for youth, and the
30 AMA and AAP spoke out against these instances²³⁻²⁵; and
31

32 Whereas, Several other medical organizations, including the American Academy of Child and
33 Adolescent Psychiatry, American College of Physicians, American Psychiatric Association,
34 American Psychological Association, Endocrine Society, and Pediatric Endocrine Society, have
35 spoken against these bills restricting gender-affirming care for transgender youth²⁶⁻³¹; and
36

37 Whereas, Over the last few years, the AMA has written several correspondences to state
38 governments and the National Governors Association to oppose legislative efforts to restrict and
39 criminalize gender-affirming care for minors³²⁻³⁸; and
40

41 Whereas, The American Medical Association supports “treatment models for gender diverse
42 people that promotes informed consent, personal autonomy, increased access for gender
43 affirming treatments and eliminates unnecessary third party involvement outside of the
44 physician-patient relationship in the decision making process” (AMA Policy H-140.824);
45 therefore be it
46

47 **RESOLVED**, That our American Medical Association work with state and specialty societies and
48 other interested organizations to oppose any and all criminal and other legal penalties against
49 patients seeking gender-affirming care and against parents and guardians who support minors
50 seeking and receiving gender-affirming care; including the penalties of loss of custody and the
51 inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action);
52 and be it further

1 RESOLVED, That our AMA advocate for protections from violence, criminal or other legal
2 penalties, adverse medical licensing actions, and liability, including responsibility for future
3 medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and
4 other healthcare providers who provide gender-affirming care; and (c) patients seeking and
5 receiving gender-affirming care (Directive to Take Action); and be it further
6

7 RESOLVED, That our AMA work with state and specialty societies and other interested
8 organizations to advocate against state and federal legislation that would prohibit or limit
9 gender-affirming care (Directive to Take Action); and be it further
10

11 RESOLVED, That our AMA work with other interested organizations to communicate with the
12 Federation of State Medical Boards about the importance of preserving gender-affirming care
13 despite government intrusions (Directive to Take Action); and be it further
14

15 RESOLVED, That our AMA amend policy H-185.927, “Clarification of Medical Necessity for
16 Treatment of Gender Dysphoria,” by insertion and deletion as follows:
17

18 **Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927**

19 Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and
20 gender incongruence, as determined by shared decision making between the patient
21 and physician, are medically necessary as outlined by generally-accepted standards of
22 medical and surgical practice; (2) will advocate for federal, state, and local policies to
23 provide medically necessary care for gender dysphoria and gender incongruence; and
24 (3) ~~opposes the criminalization and otherwise undue restriction of evidence-~~
25 ~~based gender-affirming care will support legislation, ballot initiatives and state and~~
26 federal policies to protect access to gender affirming care. (Modify Current HOD Policy)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Citation: Res. 122; A-08; Modified: Res. 05, A-16; Reaffirmed: Res. 012, A-22;

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

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

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

Citation: Res. 014, A-22;

Affirming the Medical Spectrum of Gender H-65.962

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

Citation: Res. 005, I-18;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity. Citation: Res. 010, A-17;

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience. Citation: Res. 008, A-19;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
 - a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
 - b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
 - c. Training, including collaborating with interested medical schools, residency and fellowship programs,

academic centers, and clinicians to mitigate radically diminished training opportunities;

d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Citation: Res. 621, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-23)

Introduced by: American Society for Metabolic and Bariatric Surgery
Society of American Gastrointestinal and Endoscopic Surgeons

Subject: Advocacy Against Obesity-Related Bias by Insurance Providers

Referred to: Reference Committee B

- 1 Whereas, Our American Medical Association has recognized obesity as a disease; and
2
3 Whereas, Obesity is the most common chronic disease in adulthood; and
4
5 Whereas, Untreated obesity leads to significant morbidity, premature mortality, and an enormous
6 financial burden to society from health care costs and lost productivity; and
7
8 Whereas, Our AMA is committed to promoting the highest standards of medical care and
9 improving public health; and
10
11 Whereas, Effective treatment of the disease obesity requires a comprehensive multi-disciplinary
12 approach delivered lifelong, including lifestyle therapy, anti-obesity medications, and metabolic
13 and bariatric surgery, either sequentially or in an adjuvant fashion; and
14
15 Whereas, Our AMA recognizes the importance of bariatric surgery as an effective treatment for
16 obesity and related comorbidities; and
17
18 Whereas, Metabolic Bariatric Surgery in the United States is associated with consistently low
19 mortality and morbidity rates, and
20
21 Whereas, The practice of Metabolic Bariatric Surgery in the United States is overwhelmingly
22 subjected to accreditation and oversight by the American College of Surgeons and the Society
23 for Metabolic and Bariatric Surgeons; and
24
25 Whereas, Studies have shown that access to bariatric surgery reduces healthcare costs and
26 improves patient outcomes; and
27
28 Whereas, Studies have shown that Metabolic Bariatric Surgery results in a reduction on the
29 incidence of several cancers and improves survivorship in patients with cancer; and
30
31 Whereas, In 2022, the American Society for Metabolic and Bariatric Surgery established
32 baseline criteria for the indications for the practice of metabolic surgery based on the available
33 scientific evidence; and
34
35 Whereas, Despite ample evidence to the contrary, many public and private insurance providers
36 currently impose arbitrary restrictions and discriminatory practices that limit or deny coverage for
37 metabolic surgery, such as mandatory preoperative weight management programs and time-
38 based delays. Such tactics discourage patients from completing preoperative programs and
39 lead to continued comorbidity related to the disease of obesity; and

1 Whereas, Recent AMA policy D-440.954, “*Addressing Adult and Pediatric Obesity*,” establishes
2 the AMA as working to improve national understanding of the obesity epidemic and address gaps
3 in medical obesity education and health disparities, and the lack of insurance coverage for
4 obesity treatment; therefore be it
5

6 RESOLVED, That our American Medical Association urge individual state delegations to directly
7 advocate for their state insurance agencies and insurance providers in their jurisdiction to
8

- 9 1. Revise their policies to ensure that bariatric surgery is covered for patients
10 who meet the appropriate medical criteria.
- 11 2. Eliminate criteria that place unnecessary time-based mandates that are not
12 clinically supported nor directed by the patient’s medical provider
- 13 3. Ensure that insurance policies in their states do not discriminate against
14 potential metabolic surgery patients based on age, gender, race, ethnicity,
15 socioeconomic status.
- 16 4. Advocate for the cost-effectiveness of all obesity treatment modalities in
17 reducing healthcare costs and improving patient outcomes (Directive to Take
18 Action); and be it further
19

20 RESOLVED, That the AMA support and provide resources to state delegations in their efforts to
21 advocate for the reduction of bias against patients that suffer from obesity for the actions listed.
22 (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Addressing Adult and Pediatric 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 work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. 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.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
 - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.

- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.

6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.

7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. above.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22;

Reference Committee C

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies
- 02 Financing Medical Education
- 03 Financial Burdens and Exam Fees for International Medical Graduates
- 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance
- 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
- 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants
- 07 Management and Leadership Training in Medical Education
- 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
- 09 The Impact of Midlevel Providers on Medical Education

Resolution(s)

- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations
- 303 Medical School Management of Unmatched Medical Students
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
- 305 Indian Health Service Graduate Medical Education
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
- 309 Against Legacy Preferences as a Factor in Medical School Admissions
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
- 311 Residency Application Support for Students of Low-Income Backgrounds
- 312 Indian Health Service Licensing Exemptions
- 313 Filtering International Medical Graduates During Residency or Fellowship Applications
- 314 Support for International Medical Graduates from Turkey

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 01-A-23

Subject: Council on Medical Education Sunset Review of 2013
House of Delegates' Policies

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA's policy database is
3 current, coherent, and relevant:
4

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

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

23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy,
25 or has been accomplished.
26

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

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

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

1 RECOMMENDATION

2

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

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-295.960	Clinical Skills Training in Medical Schools	<p>Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the “preclinical” years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.</p> <p>(Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13)</p>	<p>Retain clause 2, which is still relevant and not superseded by other AMA policy, and sunset clauses 1, 3, and 4, to read as follows:</p> <p>“Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the “preclinical” years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.”</p> <p>The contents of clause 1 are required of medical school programs with accreditation from the Liaison Committee on Medical Education (LCME) and is reviewed periodically, and are reflected in H-295.995 (12) (17a) (17b), “Recommendations for Future Directions for Medical Education,” which read:</p> <p>“(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its</p>

		<p>contribution to the total program should be conducted.”</p> <p>“(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.”</p> <p>Clauses 3 and 4 have been accomplished and are reflected in other AMA policy, such as D-295.988, “Clinical Skills Assessment During Medical School,” which reads in part:</p> <p>“2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.</p> <p>“3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow</p>
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			<p>international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. . . .</p> <p>“5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.</p> <p>“6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.”</p>
D-295.982	Model Pain Management Program For Medical School Curricula	Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-13)	Sunset; this directive has been accomplished.
D-300.999	Registration of Accredited CME Sponsors	<p>1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit.</p> <p>2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the</p>	<p>Retain clause 1. Still relevant.</p> <p>Sunset clause 2. Accomplished though the publication of the PRA booklet in 2017.</p> <p>New version to read as follows:</p> <p>1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit.</p> <p>2. Our AMA will remind all accredited</p>

		credit awarded at the request of the physician. (CME Rep. 4, A-00; Reaffirmed: CME Rep. 2, A-10; Appended: CME Rep. 7, A-13)	CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.”
D-305.960	Loan Repayment for Physicians in State Designated Shortage Areas	Our AMA: (1) will educate membership about various opportunities surrounding loan repayment through mechanisms including but not limited to: a designated state contact, web resources, and informative meetings, so that residents can make an informed decision regarding employment; (2) will advocate equal tax benefits for physicians who practice in either state-designated or federally-designated shortage areas; and (3) acknowledges and continues to support initiatives that facilitate recruitment of physicians to designated shortage areas. (Res. 328, A-09; Reaffirmation A-13)	Sunset; still relevant, but superseded by and reflected in other AMA policy, such as H-305.925 , “Principles of and Actions to Address Medical Education Costs and Student Debt” and H-200.949 (16), “Principles of and Actions to Address Primary Care Workforce.”
D-305.973	Proposed Revisions to AMA Policy on the Financing of Medical Education Programs	Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in	Retain; still relevant, with name change as shown below: Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

		<p>children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)</p>	
<p>D-305.986</p>	<p>Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid</p>	<p>Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the “cost of attendance” and as an educational expense for the purposes of student budgets and financial aid in medical schools; and (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the “cost of attendance”</p>	<p>Sunset. The LCME does not mandate school policies at this level of specificity. Further, elements included in defining “cost of attendance” are relevant to and guided by lenders and financial aid rules.</p>

		and as an educational expense for the purposes of student budgets and financial aid. (Res. 301, A-03; Modified: CME Rep. 2, A-13)	
D-310.953	Exploring the Feasibility of Clinic-Based Residency Programs	Our AMA: (1) advocates that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access; and (2) encourages that pilot studies of clinic-based residency program expansion be funded by private sources. (Res. 906, I-13)	Sunset; this directive has been accomplished.
D-310.954	Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies	Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. (Res. 317, A-13)	Retain; still relevant, but rescind and append to H-295.890, "Medical Education and Training in Women's Health," to read as follows. Also, note editorial changes to clauses 6 and 7: "Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women's health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served; (4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training; (5) encourages the development of a curriculum inventory and database in

			<p>women's health for use by medical schools and residency programs; (6) encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development; and (7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various <u>ACGME Residency Review Committees</u> to promote attention to women's health in accreditation standards; <u>(8) will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and</u> <u>(9) encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics."</u></p>
<p>D-35.980</p>	<p>Primary Care Physician Supply</p>	<p>Our AMA will continue to work with interested stakeholders to gather and disseminate data regarding the primary care physician supply. (Res. 217, I-13)</p>	<p>Sunset; still relevant, but already reflected in H-200.949 (25), "Principles of and Actions to Address Primary Care Workforce," which reads as follows: "Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice."</p>

<p>H-200.992</p>	<p>Designation of Areas of Medical Need</p>	<p>The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; CLRPD Rep. A, I-92; CME Rep. 2, A-03; CME Rep. 2, A-13)</p>	<p>Sunset. Accomplished through the Health Resources and Services Administration’s consolidation of federal shortage area designations.</p>
<p>H-200.994</p>	<p>Health Workforce</p>	<p>The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient’s medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Sunset; still relevant, but reflected in other, more recent policies, including H-160.950, “Guidelines for Integrated Practice of Physician and Nurse Practitioner”; H-160.906, “Models / Guidelines for Medical Health Care Teams”; and “Code of Medical Ethics 10.5.”</p>
<p>H-255.970</p>	<p>Employment of Non-Certified IMGs</p>	<p>Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.</p>	<p>Retain; still relevant, with editorial changes as shown below. All physicians practicing medicine should be licensed. The ECFMG (a member of Intealth) is the organization that evaluates the credentials of international physicians, so it is important that all physicians training in non-U.S.-based medical schools be vetted through the ECFMG. “Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, <u>ECFMG (a member of Intealth)</u> nor have met state criteria for full licensure; and</p>

		(Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)	“(2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs.”
H-255.976	Speech Tests for International Medical Graduates	The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, as state medical boards have differing policies. Note editorial change below, to ensure congruence in terminology with the policy above: “The AMA encourages state licensing boards to accept ECFMG certification <u>by the ECFMG (a member of Intealth) as satisfying the in-satisfaction of</u> requirements for demonstrating English language competence.”
H-255.985	Graduates of Foreign Health Professional Schools	(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03; Reaffirmed: CME Rep. 2, A-13)	Sunset. Still relevant, but already reflected in other policy, such as H-255.988, “AMA Principles on International Medical Graduates,” which reads in part: “6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.” “8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.” Also superseded by H-255.966 , “Abolish Discrimination in Licensure of IMGs,” which reads in part as shown (also note editorial change to clause 3, below): “A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. . . .”

			<p>“2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.</p> <p>“3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates (<u>a member of Intealth</u>) and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.</p> <p>“4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.”</p>
H-275.959	Cognitive Exams	<p>It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Sunset; still relevant, but superseded by H-275.916, “Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum.”</p>
H-275.998	Physician Competence	<p>Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such</p>	<p>Retain; still relevant.</p>

		<p>physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful.</p> <p>(4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine.</p> <p>(5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent.</p> <p>(6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.)</p> <p>(CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)</p>	
<p>H-295.900</p>	<p>Creating an Effective Environment for Medical Student Education</p>	<p>1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.</p> <p>2 .Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through</p>	<p>Sunset. This has already been accomplished, and clause 2 is an LCME requirement, as stipulated in LCME standard 3.6, Student Mistreatment:</p> <p>“A medical school develops effective written policies that define mistreatment, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing mistreatment. Mechanisms for reporting mistreatment are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation.”</p>

		<p>the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.</p> <p>(CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13)</p>	
H-295.927	Medical Student Health and Well-Being	<p>The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.</p> <p>(BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Sunset. LCME Element 12.8, “Student Exposure Policies/Procedures,” (see below) addresses this policy, except for “feasibility of financial assistance” (in this regard, LCME requires disability insurance for medical students).</p> <p>“A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following:</p> <ul style="list-style-type: none"> - The education of medical students about methods of prevention - The procedures for care and treatment after exposure, including a definition of financial responsibility - The effects of infectious and environmental disease or disability on medical student learning activities <p>“All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.”</p>
H-295.933	Medical School Affiliations With VA Medical Centers	<p>The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical schools are maintained.</p> <p>(Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03;</p>	<p>Retain, still relevant, with editorial change to title and policy to specify the acronym “VA,” as shown below:</p> <p>Medical School Affiliations With Veterans Affairs (VA) Medical Centers</p>

		Reaffirmed: CME Rep. 2, A-13)	“The AMA will work to ensure that the successful relationships between <u>Veterans Affairs (VA)</u> academic medical centers and the nation's medical schools are maintained.”
H-295.940	Recruiting Students of Medicine at the Elementary and High School Levels	The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant, as reflected in the AMA’s Doctors Back to School program.
H-295.984	Family Medicine as a Fundamental Subject in Medical Schools	The AMA recommends that U.S. medical schools include family medicine as a clinical subject. (Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant. As of the 2021-22 academic year, 23 (15 percent) of the 155 LCME-accredited schools did not report that they offered family medicine as a separate required clerkship or as part of a longitudinal integrated clerkship. Family medicine is a required element of all COCA-accredited medical schools.
H-300.964	Medical Ethics and Continuing Medical Education	The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.966	Continuing Medical Education for Physicians in the Hospital Setting	It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.983	Community Hospital Continuing Medical Education	1. The AMA believes that quality, patient-centered, cost-effective continuing medical education is important for hospital medical staffs, and that	Retain; still relevant.

		<p>the cooperative efforts of hospitals, state and county medical societies, and academic medical centers contribute to achieving this goal.</p> <p>2. Our AMA will advocate for the availability of accessible, affordable, high-quality continuing medical education for small rural and community hospitals.</p> <p>(CME Rep. D, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 316, A-13)</p>	
H-310.908	Support for Residents and Fellows During Family and Medical Leave Time	<p>Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.</p> <p>(Res. 307, A-13)</p>	Sunset; still relevant, but superseded by and reflected in H-405.960 , "Policies for Parental, Family and Medical Necessity Leave."
H-310.913	Physician Extenders	<p>1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training.</p> <p>2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.</p> <p>(Res. 208, I-10; Appended: CME Rep. 8, A-13)</p>	Retain; still relevant.
H-310.946	Training Physicians in Non-Traditional Sites	<p>It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes.</p> <p>(Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03;</p>	Retain, still relevant, but incorporate into the more expansive Policy H-200.949 (13), "Principles of and Actions to Address Primary Care Workforce," which reads:

		Reaffirmed: CME Rep. 2, A-13)	“13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs <u>and those in non-traditional sites, including nursing homes</u> , and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).”
H-310.952	Housestaff Input During the ACGME Review Process	The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Sunset; this has been accomplished and is in place at the ACGME, through resident surveys during program site visits.
H-310.976	Gender-Based Questioning in Residency Interviews	The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the “Common Requirements” and the “Institutional Requirements” of the “Essentials of Accredited Residencies,” to ensure that there is no gender-based bias.	Retain clause 1; still relevant, and sunset clauses 2 and 3 for the reasons noted below. Updated version to read: “The AMA opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination.” Sunset clause 2, as this has been accomplished, with FREIDA including program data on the maximum number of paid and unpaid days for family/medical leave as well as a hyperlink to programs’ leave policies. Sunset clause 3, as the Council on Medical Education reviews all proposed changes to program and institutional requirements and provides feedback as needed. The ACGME has also placed

		(Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	significant emphasis on equity, including the elimination of bias across the board.
H-310.997	Accreditation of Graduate Medical Education Programs	<p>(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Retain, still relevant, with editorial changes as shown below, in that (1)(b) and (2) are essentially the same.</p> <p>“(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice.”</p>
H-330.950	Post-Licensure Assessment as a Condition for Physician Participation in Medicare	<p>The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Retain; still relevant. The AMA continues to oppose extraneous evaluations of physicians that create burdens and are not based on evidence that they will improve care quality or patient safety. In addition, physicians are already subject to multiple assessments of their competence and ability to practice medicine, through maintaining licensure, certification, and credentials/privileges, such that any additional assessment would be duplicative. Finally, imposing an assessment as a requirement for Medicare</p>

			participation may create additional burden that would drive some physicians to end their Medicare participation, threatening access to care for some of the nation's most vulnerable populations.
H-35.978	Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital	The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.
H-360.997	Nursing Education	The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.

<p>D-630.974</p>	<p>Health Care Recovery Fund</p>	<p>Our AMA will: (1) convey to the AMA Foundation its desire that medical students, resident physicians and fellows, and young physicians be given special consideration and priority, along with all other physicians, beyond rebuilding medical practices, based on their degree of need, in distributions from any special disaster recovery funds; and (2) work with interested state and national medical specialty societies to publicize the existence of any special AMA Foundation disaster recovery funds and to identify and encourage applications from deserving recipients, especially among those who are medical students, resident physicians and fellows, and young physicians, and that these names be shared with the AMA Foundation as it considers grants from such funds. (Res. 605, A-06; Reaffirmed: CCB/CLRPD Rep. 3, A-12)</p>	<p>Sunset; this has been accomplished.</p>
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REPORT 02 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Financing Medical Education (Resolution 306-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

As the cost of medical education continues to rise, it is imperative to understand the factors that impact this investment. These factors include the type of institution one attends, the cost of attendance, and a student's education and noneducation debt. Private institutions tend to cost more than public institutions, with private nonprofit institutions being more expensive than private for-profit institutions. Cost of attendance is determined by the published tuition and required fees; books and supplies; and the weighted average cost for room, board, and other expenses for four years at each institution. Education debt encompasses both premedical and medical education debt. Education debt incurred before starting medical school remains remarkably stable, as is the percentage of graduates reporting such debt. While private medical school graduates are slightly less likely to have debt, their individual debt levels are typically higher than public school graduates as private schools tend to be more expensive to attend than public schools. The Council on Medical Education recognizes that cost and debt is not necessarily a 1:1 relationship and believes these factors should not be conflated.

While costs to attend medical school are rising, another interesting trend is also emerging—a decline in the percentage of graduates who have debt. The proportion of those reporting no debt seems to be clustered among students from wealthy backgrounds. Earlier research supports that household income and education levels are tightly linked in the United States. Specifically, higher levels of education are correlated with higher household income and vice versa.

There are also variations in student indebtedness by race and ethnicity. In 2019, Black allopathic and osteopathic medical graduates had the highest median education debt. Asian allopathic and osteopathic medical graduates had the lowest median education debt. In that same year, 91 percent of Black allopathic medical graduates, 84 percent of Hispanic allopathic medical graduates, and 80 percent of American Indian allopathic medical graduates reported having medical education debt compared to 75 percent of white allopathic medical graduates and 61 percent of Asian allopathic medical graduates. Among all osteopathic graduates who reported debt in 2019, 92 percent were Black, 84 percent were Hispanic, 85 percent were white, and 74 percent were Asian.

While indebtedness impacts most graduates, the majority do not enter loan forgiveness programs. While the time to pay off debt varies, compensation after residency is enough to repay all levels of educational debt. The cost of medical education and student debt are likely to be barriers to diversity in the physician workforce and deterrents for potential applicants with fewer financial resources. However, the cost of medical education does not appear to be a factor in limiting the overall size of the applicant pool as the majority applicants tend to come from backgrounds with higher socioeconomic status.

The Council on Medical Education recommends reaffirming AMA Policy D-305.952, “Medical Student Debt and Career Choice”; amending Policy D-295.316, “Management and Leadership for Physicians”; amending Policy H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt”; and adopting new policy encouraging higher utilization of financial information available through medical education organizations in addition to federal, state, and local financial resources.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-A-23

Subject: Financing Medical Education (Resolution 306-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 American Medical Association (AMA) Policy D-305.951, “Medical Education Debt Cancellation
2 in the Face of a Physician Shortage During the COVID-19 Pandemic,” directs our AMA to:

3
4 Study the issue of medical education debt cancellation and consider the opportunities for
5 integration of this into a broader solution addressing debt for all medical students and
6 physicians.

7
8 In addition, Resolution 306-A-22, “Creating a More Accurate Accounting of Medical Education
9 Financial Costs,” introduced by the Illinois Delegation and the American Society of
10 Anesthesiologists, asked that the AMA “study the costs of medical education, taking into account
11 medical student tuition and accrued loan interest, to come up with a more accurate description of
12 medical education financial costs.” This item was referred by the House of Delegates (HOD) to
13 explore the issue of debt cancellation further and develop recommendations for broader solutions to
14 medical student and physician indebtedness. This integrated report is in response to both the policy
15 directive and the referral.

16 BACKGROUND

17 *The price of medical education*

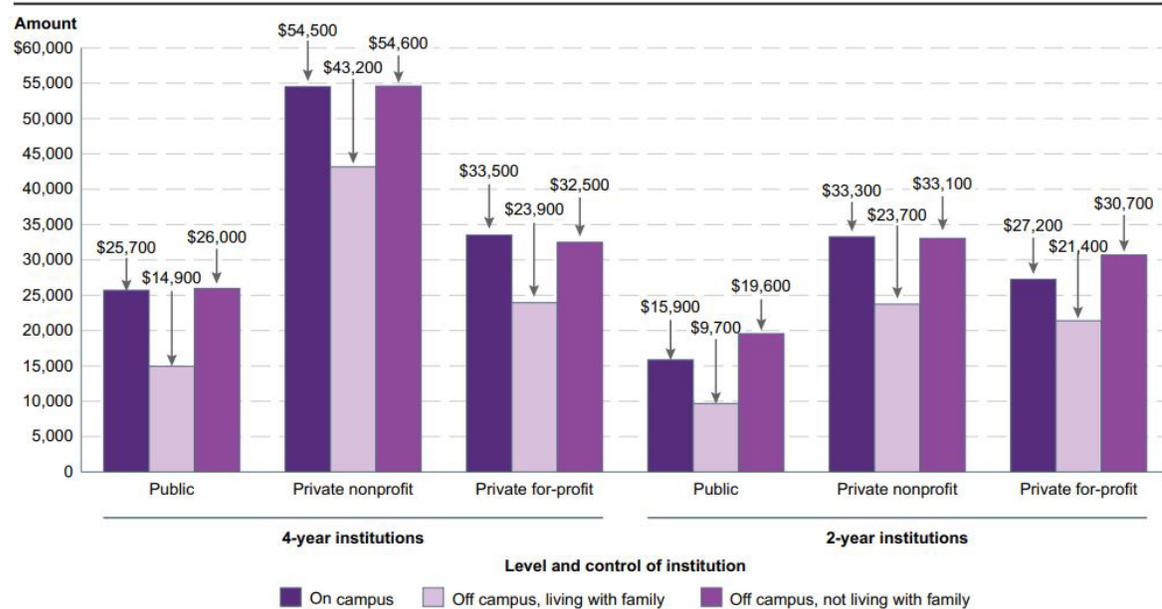
18
19
20
21 The road to becoming a physician has increasingly become an expensive one, with each step
22 having associated costs. For some, the road includes private tutoring, test preparation courses,
23 and/or postbaccalaureate premedical programs. Beyond tuition and student fees, costs toward
24 becoming a physician also include the Medical College Admission Test[®] (MCAT[®]); applications to
25 medical school; the United States Medical Licensing Examination[®] (USMLE[®]) and/or the
26 Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-
27 USA); and applications for residency, board certification, and state licensure. Some physicians also
28 assume responsibility for the cost of their education beginning with their undergraduate education;
29 this has been factored into the discussion of premedical education debt to create a more
30 comprehensive description of medical education financial costs. It is also important to emphasize
31 that cost and debt are not necessarily a 1:1 relationship, and the Council believes these factors
32 should not be conflated.

33
34 Several studies have attempted to determine the cost of education for medical students. A study
35 conducted in 1997 at the University of Texas-Houston Medical School found that the annual total
36 cost (instructional, educational, and research) of the educational program was \$90,660 per student
37 in the 1994-95 academic year.¹ This same study developed a cost-construction model to assess the
38 cost for educating undergraduate medical education (UME) students at the institution. The study

1 identified the cost of the entire program as well as instructional costs (direct-contact teaching),
 2 educational costs (instructional costs plus supervision), and milieu costs (educational costs plus
 3 research costs) and provides a glimpse into some of the costs tuition covers. Another study that
 4 same year reviewed 20 years of published data and determined that total educational resource costs
 5 fell into a range of \$72,000 to \$93,000 per student per year in 1996 dollars, or approximately
 6 \$136,800 - \$176,700 in 2023.²

7
 8 The National Center for Education Statistics monitors cost trends for undergraduate institutions.
 9 Total cost of attendance (COA) is determined by the published tuition and required fees; books and
 10 supplies; and the weighted average cost for room, board, and other expenses for four years at each
 11 institution. The average COA can be varied when considering a student’s living arrangement (e.g.,
 12 a student may live on campus; off campus with family; or off campus but not with family). To
 13 demonstrate the range in COA for students, the average COA for a full-time student enrolled in a
 14 baccalaureate program at a four-year public institution living off campus with family was \$14,900
 15 in academic year (AY) 2020-2021. In that same year, the average COA for a full-time student
 16 enrolled in a baccalaureate program at a four-year private nonprofit living off campus, not with
 17 family, was \$54,600.³ Figure 1 further illustrates the range of total costs for baccalaureate
 18 programs by type of institution and student living situation.

Figure 1. Average total cost of attending degree-granting institutions for first-time, full-time undergraduate students, by level and control of institution and student living arrangement: Academic year 2020–21. Reprinted from the National Center for Education Statistics. (2020). Price of attending an undergraduate institution. The Condition of Education. Accessed January 2023. https://nces.ed.gov/programs/coe/pdf/2022/cua_508.pdf.



NOTE: Data are for the 50 states and the District of Columbia. The total cost of attending a postsecondary institution includes tuition and required fees; books and supplies; and the average cost for room, board, and other expenses. Student charges data for 2019–20 were collected prior to the outbreak of the coronavirus pandemic and therefore do not reflect any adjustments institutions might have made later in the academic year due to the pandemic. Tuition and fees at public institutions are the lower of either in-district or in-state tuition and fees. Excludes students who previously attended another postsecondary institution or who began their studies on a part-time basis. Data are weighted by the number of students at the institution who were awarded Title IV aid. Title IV aid includes grant aid, work-study aid, and loan aid. Although rounded numbers are displayed, the figures are based on unrounded data.
 SOURCE: U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS), Winter 2020–21, Student Financial Aid component; and Fall 2020, Institutional Characteristics component. See *Digest of Education Statistics 2021*, table 330.40.

19 The variation in COA continues through medical school. According to the Association of
 20 American Medical Colleges (AAMC), the median four-year COA in 2019 at a public allopathic
 21 medical school was \$250,222 and \$330,180 at a private allopathic medical school.⁴ For osteopathic
 22 medical colleges, in AY 2021-2022, the average four-year COA at a public osteopathic medical
 23 college was \$281,946 and \$337,144 at a private osteopathic medical college.⁵ As of 2022, of the

1 total 155 allopathic medical schools, 93 are public and 62 are private.⁶ Of the 38 accredited
2 colleges of osteopathic medicine, 31 of the schools are private and seven of the schools are public.⁷

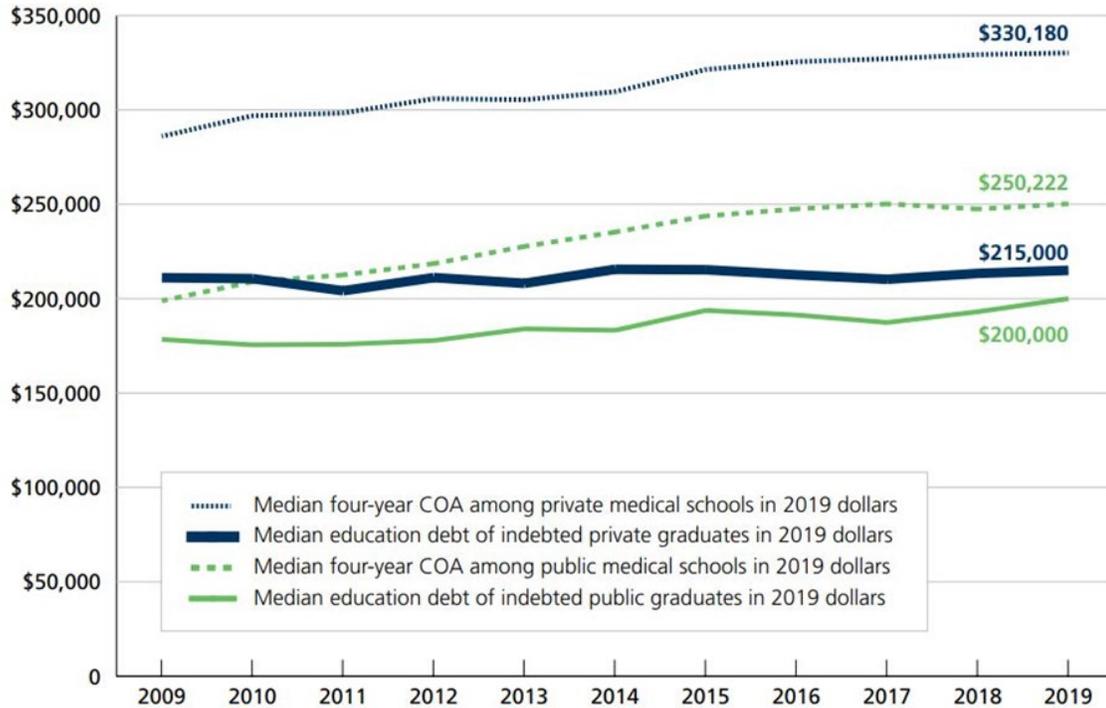
3
4 *Data on cost of attendance and education debt*

5
6 The AAMC utilizes several tools to assess trends related to COA and education debt, including the
7 Tuition and Student Fees Questionnaire (TSF), the AAMC Medical School Graduation
8 Questionnaire (GQ) and the Liaison Committee on Medical Education (LCME) Part 1B Student
9 Financial Aid Questionnaire. The TSF is administered to all allopathic medical schools to assess
10 tuition, fees, and health insurance costs for both resident and nonresident students reported by
11 accredited medical education programs. The GQ is administered annually to all graduating medical
12 students to evaluate the medical school programs and medical student experiences, including
13 financial aid and indebtedness. The LCME Part 1B Student Financial Aid Questionnaire is
14 administered annually to allopathic medical schools and incorporated into the AAMC's Medical
15 School Profile System to provide schools with benchmarking reports. The American Association of
16 Colleges of Osteopathic Medicine (AACOM) also assesses trends related to COA and education
17 debt through its Annual Osteopathic Medical School Questionnaire and Graduating Seniors
18 Survey. The Osteopathic Medical School Questionnaire is administered to osteopathic medical
19 colleges.

20
21 When discussing medical student debt and the resolution of that debt, the terms loan forgiveness
22 and debt cancelation are often used interchangeably. According to the U.S. Federal Student Aid
23 website, the terms "mean nearly the same thing," with the difference being mainly in the
24 circumstances surrounding the termination of requirements to repay the loan.

25
26 The type of school a student attends is a factor in determining their potential debt level. Further,
27 costs of attending medical school may vary by year at the same school due to fluctuation in tuition
28 and fees and tends to be more expensive in the third and fourth year.⁸ While private medical school
29 graduates are slightly less likely to have debt, their individual debt levels are typically higher than
30 those of public school graduates as private schools tend to cost more to attend than public schools.
31 Additionally, public schools generally enroll more students. Figure 2 highlights the median COA
32 among private and public schools compared to the education debt of allopathic medical school
33 graduates who attended private and public schools.

Figure 2. Inflation-adjusted median education debt levels and four-year cost of attendance (COA), 2009-2019 (in constant 2019 dollars). Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

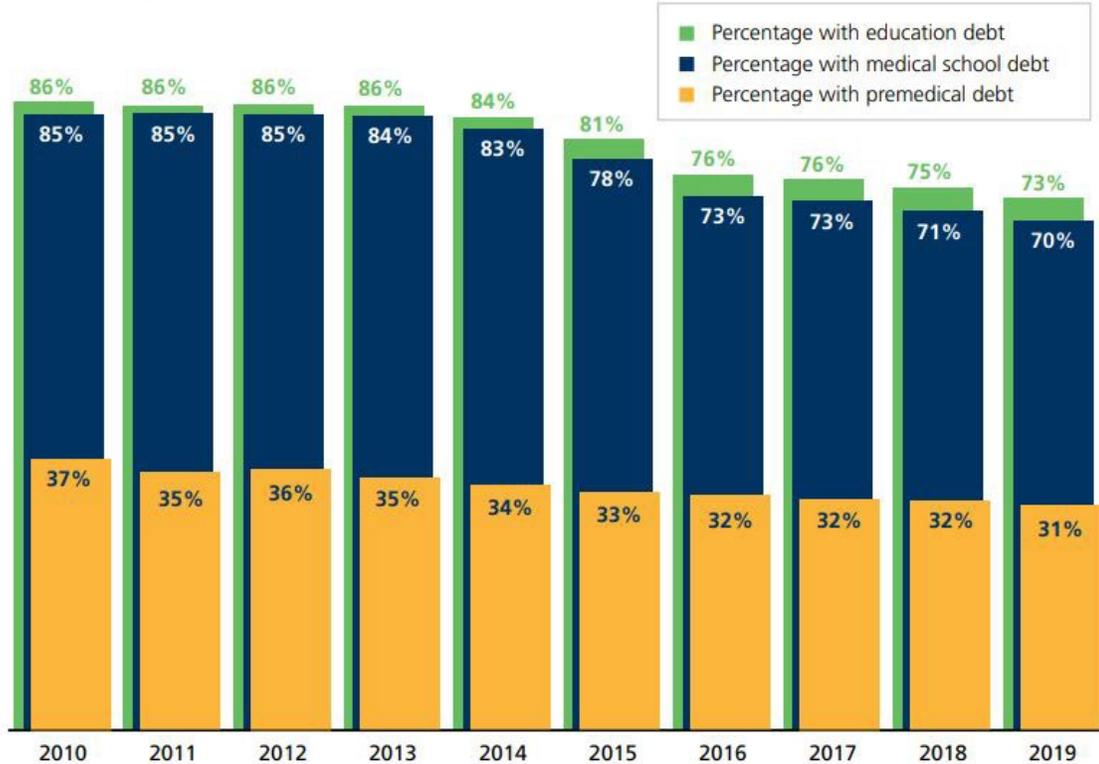


Source: AAMC Medical School Graduation Questionnaire (GQ) and Tuition and Student Fees Questionnaire (TSF).

1 While costs to attend medical school are rising, another emerging trend indicates a decline in the
 2 percentage of graduates who have debt. In 2013, the AAMC found that 14 percent of graduates had
 3 no debt. This percentage nearly doubled to 27 percent in 2019.⁹ While the proportion of those
 4 reporting no debt seems to be clustered among students from wealthy backgrounds, several other
 5 variables have been identified to explain this decline, including the impact of new allopathic
 6 medical schools, changes to federal loan programs, increased use of scholarships, and changes in
 7 self-reported parental income. Additionally, a 2021 [report](#) by the Council on Medical Education,
 8 “Medical Student Debt and Career Choice,” revealed that the data in aggregate may conceal the
 9 actual debt load faced by individual students and that a significant subset of students have outside
 10 funding sources to offset debt.

11
 12 Annual levels of premedical school debt, which is education debt incurred before starting medical
 13 school, are remarkably stable, as is the percentage of graduates reporting such debt. According to
 14 the AAMC GQ, roughly one-third of allopathic medical graduates reported having premedical
 15 school debt, and the median premedical school debt amount was exactly \$25,000 in each of the
 16 past four years. Osteopathic medical graduates reported higher levels of pre-medical education
 17 debt: \$51,116 in 2021, \$51,230 in 2020, and \$52,348 in 2019.¹⁰ Figure 3 illustrates the percentage
 18 of U.S. allopathic medical school graduates with education, medical school, and premedical school
 19 debt from 2010 to 2019.

Figure 3. Percentage of U.S. medical school graduates with education, medical school, and premedical debt, 2010-2019. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.



Source: AAMC Medical School Graduation Questionnaire (GQ).

1 The education debt of graduates varies by family income level. In 2019, the AAMC Matriculating
 2 Student Questionnaire (MSQ) found that as the level of family income increases, the percentage of
 3 funds projected to come from personal/family sources rises and the percentage from loans and
 4 scholarships declines. This finding is consistent with data from the AACOM Graduating Seniors
 5 Survey. For the past 30 years, data regarding debt and family income have been consistent, with
 6 more than half of medical school graduates belonging to families in the top quintile of U.S. family
 7 income. Earlier research supports that household income and education levels are tightly linked in
 8 the United States. Specifically, higher levels of education are correlated with higher household
 9 income and vice versa.^{11,12} This is consistent with the 2019 AAMC GQ data, which found that the
 10 higher the family income level, the less likely graduates are to have premedical debt. Figure 4
 11 illustrates the relationship between family income and premedical debt.

Figure 4 . Percentage of 2019 medical school graduates with premedical debt and median premedical debt amount by quintile of family income. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Quintile of U.S. Income	Sample in this family income quintile	With premedical debt	Median premedical debt for those with such debt
1st (Lowest)	4%	51%	\$30,000
2nd	7%	49%	\$27,000
3rd	10%	51%	\$25,000
4th	23%	45%	\$25,000
5th, top 81%-95%	30%	30%	\$25,000
5th (Highest), top 5%	26%	12%	\$27,750
Family income not provided	N/A	28%	\$27,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019, and corresponding Matriculating Student Questionnaire (MSQ). Family income quintiles are based on U.S. Census data.

1 There are also variations in student indebtedness by race and ethnicity. In 2019, 91 percent of
 2 Black allopathic medical graduates, 84 percent of Hispanic allopathic medical graduates, and 80
 3 percent of American Indian allopathic medical graduates reported having medical education debt
 4 compared to 75 percent of white allopathic medical graduates and 61 percent of Asian allopathic
 5 medical graduates. Among allopathic medical school graduates who reported multiple
 6 combinations of race and ethnicity or “other,” 71 percent reported having educational debt.¹ In that
 7 same year and among all osteopathic graduates who reported debt, 92 percent were Black, 84
 8 percent were Hispanic, 85 percent were white, and 74 percent were Asian. Those who indicated
 9 they were American Indian and Alaska Native, Native Hawaiian and Pacific Islander or multiple
 10 races were categorized as “all others” and in this group 74 percent reported debt.⁵ Due to the
 11 limited number of AI/NA osteopathic medical graduates, their median education debt is unknown.
 12

13 In 2019, Black allopathic and osteopathic medical graduates had the highest median education
 14 debt, of \$230,000 and \$304,908, respectively. Asian allopathic and osteopathic medical graduates
 15 had the lowest median education debt, at \$180,000 and \$229,921, respectively. Hispanic allopathic
 16 and osteopathic medical graduates had median education debt of \$190,000 and \$299,946,
 17 respectively. White allopathic and osteopathic medical graduates had a median education debt of
 18 \$200,000 and \$270,000, respectively. AI/AN allopathic medical graduates had the second highest
 19 median education debt, at \$212,375.^{1,5}
 20

21 The Council on Medical Education recently reported that claims that education debt influences
 22 specialty choice are unfounded and “a comprehensive review of the academic literature yielded
 23 numerous research reports indicating little to no connection between specialty choice and economic
 24 factors such as debt and income potential.¹³ Phillips et al. found that “students from lower-income
 25 families are more likely to eventually practice primary care. Additionally, public school graduates
 26 were 30 percent more likely to choose primary care and twice as likely to select family medicine”
 27 as a subspecialty.¹⁴ Additionally, Kahn and Nelling found that “pursuing a medical degree is
 28 financially beneficial” and “the numbers of physicians graduating each year has begun to increase
 29 due to gradual expansion of class sizes and the establishment of new medical schools.”¹⁵ For
 30 instance, 16 allopathic medical schools, and 12 osteopathic medical schools have opened in the
 31 past 10 years. This finding is further supported by the AAMC and AACOM, as both have
 32 witnessed an increase in the number of applicants and overall enrollments over the last decade for
 33 allopathic and osteopathic medical school programs.^{16,17}
 34

35 Data from the AAMC demonstrate that the number of applicants to allopathic medical schools has
 36 increased from 48,014 in AY 2013-14 to 62,443 in AY2021-22 for an increase of 30 percent. For

1 the same period, matriculants increased from 20,055 to 22,666 for an increase of 13 percent. The
 2 same data demonstrate a matriculant to applicant ratio of 0.41 in 2013-14 decreasing to 0.36 in
 3 2021-22 despite an increase in the number of schools and total number of admissions. Collectively,
 4 these data suggest that increasing cost of medical education and rising student debt are not limiting
 5 interest or enrollment in medical education.

6
 7 *Data on Noneducation Debt*

8
 9 The AAMC GQ also analyzes noneducation debt in five categories: credit card, car, residency
 10 relocation loan, mortgage, and other. The AAMC GQ data from 2019 highlight that noneducation
 11 debt is not common and the median amounts (excluding mortgages) are significantly lower than the
 12 median education debt amounts. Figure 5 provides an overview of the noneducation debt data for
 13 allopathic medical school graduates in 2019.

Figure 5. Noneducation debt data for medical school graduates, 2019. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Type of noneducation debt	Percentage with this debt	Median amount for graduates with this debt
Credit card	13%	\$5,000
Car loan	7%	\$10,000
Residency relocation loan	3%	\$10,000
Other debt	1%	\$9,000
Sum of all four nonmortgage debt categories	18%	\$10,000
Mortgage	4%	\$150,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: The percentage values were rounded off.

14 The following combinations were the most reported in the subset of graduates with noneducation
 15 debt: 45 percent reported having credit card debt only, 18 percent reported having car debt only, 17
 16 percent reported having both credit card and car debt, and 7 percent reported having both credit
 17 card and residency relocation debt. All other possible combinations occurred less than 3 percent of
 18 the time. These findings were consistent with the 2018 data. Additionally, nonmortgage,
 19 noneducation debt was more common among graduates who identified as married or having
 20 dependents. Figure 6 divides allopathic medical graduates into four groups based on their marital
 21 status and whether they have dependents and shows their debt characteristics.

Figure 6. Percentage of selected debt characteristics of 2019 graduates by marital and dependents status. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

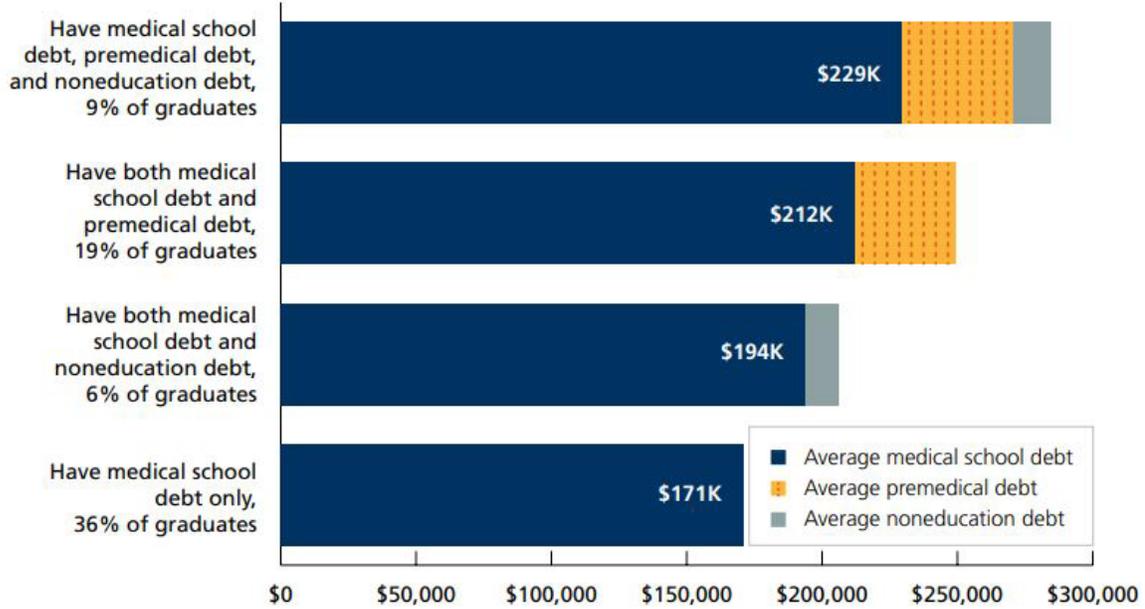
Debt Characteristic	No Dependents (93%)		With Dependents (8%)	
	Single (76%)	Married (17%)	Married (7%)	Single (1%)
Percentage of all nonmortgage, noneducation debt held	55%	21%	21%	3%
Percentage with nonmortgage, noneducation debt	15%	21%	37%	43%
Median nonmortgage, noneducation debt	\$8,000	\$10,000	\$15,000	\$15,500
Percentage of females/males	52%/48%	49%/51%	31%/69%	44%/56%
Percentage graduating from public/private medical schools	58%/42%	69%/31%	70%/30%	73%/27%
Percentage of group with education debt	72%	75%	77%	91%
Median education debt of indebted graduates	\$200,000	\$200,000	\$210,000	\$250,000

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: Nonmortgage, noneducation debt = credit card + car + residency relocation + other. Single = single (never legally married) or divorced, widowed, or separated but still legally married. Married = legally married, common law, or civil union.

1 Another pattern has emerged while surveying medical education debt. That is, the average level of
 2 medical school debt per graduate increases as the types of debt held increases. Only 30 percent of
 3 medical school graduates have no medical school debt at all. For those who do have debt, 36
 4 percent have medical school debt only, 19 percent have medical school debt and premedical school
 5 debt, and 9 percent have medical school debt, premedical school debt, and noneducation debt. Only
 6 6 percent of graduates have both medical school debt and noneducation debt. Figure 7 shows the
 7 average amount of debt among each of these groups.

Figure 7. Average medical school debt by type of debt held by 2019 indebted graduates. Noneducation debt excludes mortgage data and includes credit card, car, residency relocation, and other debt. Not shown are the 30 percent of graduates with no medical school debt. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.



Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

1 AACOM monitors non-educational debt in aggregate, categorized by graduates of public and
 2 private schools. Table 1 outlines the reported non-educational debt of graduating seniors for the
 3 most recent three years for which data are available.

Reported non-educational debt	Debt#			% in debt		
	All schools	Public	Private	All schools	Public	Private
2020-2021	\$30,486	\$28,011	\$30,881	33%	33%	33%
2019-2020	\$25,205	\$23,518	\$25,537	37%	36%	37%
2018-2019	\$24,731	\$24,834	\$24,712	38%	36%	38%

*All debt data are self-reported by respondents of the survey.

#Mean taken from responses greater than zero.

Source: American Association of Colleges of Osteopathic Medicine. 2020-2021 Academic Year, AACOM Graduating Senior Survey, Summary Report. Published October 2021. Accessed March 20, 2023.

4 *Understanding the impact of accrued interest on debt*

5

6 Paying off education debt takes a considerable amount of time. A 2019 survey of physicians who
 7 had graduated from medical school in 2015 or earlier found that 35 percent had paid off their
 8 student loans. Of the respondents that still reported debt, 80 percent had more than \$100,000 in
 9 debt and 32 percent had more than \$250,000.¹⁸ Assessing the impact of accrued interest on
 10 education debt is complicated, beginning with interest rates. Congress sets the interest rates for
 11 federal student loans, while private lenders establish their own rates. Borrowers also have the
 12 option of fixed or variable rates for their loans. Fixed loan rates remain the same for the duration of

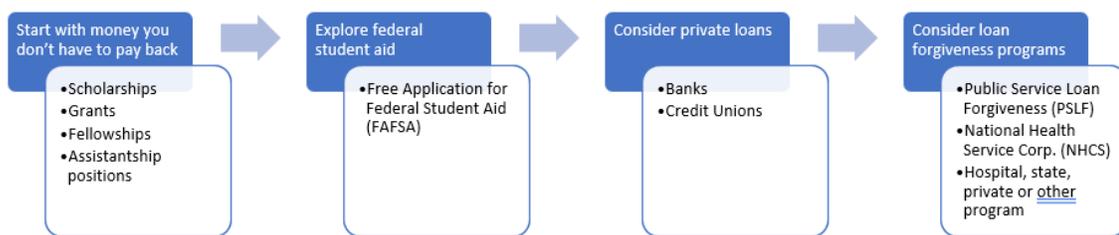
1 the repayment term. Variable interest rates are based on debt market conditions and can fluctuate
 2 over time. Like fixed rate loans, payments on variable rate loans are initially applied to the interest
 3 and then the principle. Variable interest rates tend to initially be lower than fixed interest rates, but
 4 they can increase significantly depending on market conditions, which makes them a riskier option
 5 for borrowers.¹⁹ At the time of this report, federal student loans offer fixed interest rates of 6.54
 6 percent or 7.54 percent, while private lenders offer fixed or variable interest rates ranging between
 7 3.5 to 15 percent.²⁰ If a borrower is on an extended payment plan or has deferred their payments,
 8 the interest continues to accrue. Negative amortization occurs when the monthly interest accruing
 9 is higher than the monthly loan payment one makes. Negative amortization can occur during
 10 residency; however, with rare exceptions, compensation after residency is enough to repay all
 11 levels of educational debt.

12
 13 *Mechanisms to pay for medical education*

14
 15 As discussed in an earlier Council [report](#) on medical student debt and career choice, the relative
 16 lack of financial education among medical students is a concern. A study of first- and fourth-year
 17 medical students by Jayakumar et al. found low levels of financial literacy and lack of preparedness
 18 for managing personal finances, including strategies for effective saving and investing and practice
 19 management.²¹ Equally concerning, the study’s authors describe the lack of improvement in
 20 financial literacy between entering and graduating medical students, regardless of whether their
 21 medical school offered such education.

22
 23 The AAMC Financial Information, Resources, Services, and Tools ([FIRST](#)) program provides free
 24 resources, including publications, videos, webinars, infographics, and charts to help students and
 25 residents make informed financial decisions related to their education. In addition, colleges and
 26 universities have offices of financial aid to support and assist students with their financial concerns.
 27 [Sallie Mae](#) provides guidance on how to create a plan to pay for aspiring physicians. They offer a
 28 three-step approach to help inform students how to control costs associated with medical school.
 29 The model below outlines these three steps and includes a fourth step to include loan forgiveness
 30 programs, which have been historically underutilized.

Figure 8. *Creating a plan to pay for medical school*



Source: Sallie Mae, *Paying for Medical School*, <https://www.salliemae.com/student-loans/graduate-school-information/ways-to-pay-for-graduate-school/paying-for-medical-school/>. Accessed March 20, 2023.

31 *Loan forgiveness opportunities and limitations*

32
 33 There are a variety of loan forgiveness programs at the federal, state and local level. The most
 34 popular program among medical school graduates is the Public Service Loan Forgiveness (PSLF)
 35 program. A 2017 Council [report](#), “Expansion of Public Service Loan Forgiveness,” provides
 36 additional background on the PSLF program, which promises cancellation of remaining federal

1 student loan balances after 10 years’ worth of payments made while employed by an eligible
 2 nonprofit or government agency. Payment amounts during the 10-year period are income-based.
 3 Physicians can use their time in residency toward the 10-year requirement if they make regular
 4 payments during those years and their employer is a nonprofit teaching hospital. Following
 5 residency, physicians can continue in a nonprofit for the remaining payment years.

6
 7 While indebtedness impacts most graduates, the majority do not enter loan forgiveness programs.
 8 Only 34 percent of indebted allopathic medical graduates report plans to pursue PSLF. Among
 9 indebted osteopathic medical graduates, this percentage is higher, with 50 percent reporting they
 10 will participate in a loan forgiveness program and, of those, 70 percent reporting they plan to
 11 pursue PSLF.^{2,5} Figure 9 breaks down the various details of indebted allopathic medical graduates’
 12 plans to enter loan forgiveness programs.

Figure 9. Various Details of Indebted Graduates by Plans to Enter a Loan Forgiveness Program, 2019 Only. Reprinted from Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: AAMC; 2020. Accessed January 2023.

Plan to Enter	Percentage of sample	Median education debt	Percentage of graduates of public/private schools	Education debt level		
				Lowest third <\$160,000	Middle third \$160,000-\$246,000	Highest third >\$246,000
Public Service Loan Forgiveness (PSLF)	34%	\$240,000	57%/43%	16%	36%	48%
Other Federal, including National Health Service Corps (NHSC)	3%	\$200,000	66%/34%	3%	2%	3%
Hospital, state, private, or other program	8%	\$220,000	70%/30%	6%	8%	9%
No plans to enter a program	56%	\$175,000	63%/37%	75%	53%	40%
Total percentage, median education debt, and overall percentage of respondents in public/private schools	100%	\$200,000	61%/39%	100%	100%	100%

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019.

Note: Total percentages might not equal 100 percent due to rounding. The “Other Federal” category is for the National Health Service Corps (NHSC), the Indian Health Service Corps, the armed services (Navy, Army, Air Force), and other uniformed services. Public Service Loan Forgiveness (PSLF) is a Department of Education program.

13 *The business of medical education*

14
 15 The true cost of undergraduate medical education is difficult to determine for several reasons.
 16 Medical education programs are typically imbedded in increasingly complex medical schools.
 17 Medical schools often have multiple mission areas and educational programs that share common
 18 resources and infrastructure. Faculty within the schools often have roles and responsibilities
 19 beyond the educational program, with some having minimal contribution to the education of
 20 medical students. The funding models for schools and faculty vary widely, often with funds
 21 flowing in opposing directions between medical schools and clinical affiliates. Teaching students,

1 engagement in faculty governance of the educational program, faculty development as teachers,
2 and other roles result in decreased clinical and research productivity, which in turn results in
3 opportunity cost for the medical school, clinical affiliates, and other providers. The models for
4 funding these opportunity costs vary across and within institutions, rendering an accurate cost
5 analysis difficult at best.

6
7 The effects of the increasing cost of medical education and increasing student debt on health care
8 costs in general are even more difficult to determine but may be negligible in the totality of the
9 nation's health care costs. As noted above, there are opportunity costs for clinical faculty who teach
10 medical students by way of decreased productivity. Approximately 18 percent of physicians in the
11 U.S. have faculty appointments,²² but the number of these physicians who make a significant
12 contribution to medical student teaching is unknown, as is the percentage of their time spent
13 teaching medical students and the funding source for these activities. Further, physician incomes
14 make up only 10 percent of total health care spending.²³ Taking all these factors into consideration,
15 educating medical students probably has minimal impact on current health care costs. There are
16 also direct costs incurred to support medical students in clinical settings, but these are also very
17 small in the context of a health system. Downstream, medical school graduates in clinical practice
18 have little control over clinical income by way of reimbursements, as these are largely set by third
19 party payers. In summary, while the actual effect of the cost of medical student education on the
20 health care system is not known, the contribution is probably relatively small in comparison to
21 other drivers of health care costs.

22
23 While the cost of medical education and student debt are likely to be barriers to diversity in the
24 physician workforce and deterrents for potential applicants with fewer financial resources, the cost
25 of medical education does not appear to be a factor in limiting the overall size of the applicant pool.

26 27 *Return on educational investment for physicians*

28
29 Another consideration is the reality and perception of educational debt for physicians versus
30 physician income, compared to nonphysicians. According to the U.S. Bureau of Labor Statistics
31 May 2021 report on Occupational Employment and Wage Statistics, the annual mean income for
32 physicians in general was \$252,480, with a range across specialties of \$198,420 for pediatricians to
33 \$353,970 for cardiologists. By comparison, the average income for four-year college degree
34 graduates was \$59,600, versus \$44,100 for an associate degree and \$36,600 for high school
35 graduates.²⁴ For physicians, using the general annual mean income and a 30-year full-time practice
36 life, the projected lifetime income amount would be \$7.574 million in 2021 dollars. By
37 comparison, the average tuition (not COA) for an MBA degree in 2022 was \$62,460, and the
38 annual average salary for holders of MBA degrees was approximately \$115,000,^{25,26} for a projected
39 30-year lifetime income of \$3.450 million in 2022 dollars. Further, debt repayment as a percentage
40 of income is highly likely to decrease over time, as overall income increases with inflation and
41 cost-of-living increases in income, while the amount of fixed loan repayments remains constant.
42 Taken in the context of anticipated income and the effects of inflation on the value and payments of
43 long-term loans, medical education costs and student loans are still a good long-term investment.

44
45 Of course, these calculations do not take into consideration the length of the training program and
46 the positive and negative effects of medical education on lifestyle and family. Nor do they factor
47 the disproportionate effect that the cost of medical education, and debt, may have on the
48 development of a diverse workforce. But the data clearly show that the investment in medical
49 education, even with educational debt, is a good one. Given the many benefits, both tangible (e.g.,
50 financial) and intangible (societal standing afforded physicians in the U.S.), the medical
51 community and society in general must consider if the cost of medical education and educational

1 debt of medical students is misaligned with the ability to repay the debt and with the levels of
2 income that typically follow.

3 4 SUMMARY AND RECOMMENDATIONS

5
6 Like medical school tuition, medical education debt is rising. A closer look at the data
7 demonstrates that rising education debt represents a greater burden for specific demographics of
8 medical school graduates, including those whose are in the lower quintiles of U.S. family income
9 and marginalized racial groups. Efforts to diversify the physician workforce may benefit by
10 focusing support for these groups most negatively impacted, as their experiences may contribute to
11 improve both quality of care and access to care. That said, there is little solid evidence for a strong
12 link between debt and career choice. Although the average amount of education debt for medical
13 school graduates is in the six figures, the most indebted medical school graduates do not enter loan
14 forgiveness programs and can repay any amount borrowed regardless of specialty practice or where
15 they live, in part due to the flexible nature of federal repayment plans that link payments to income
16 and expectations for income after completion of training.²⁷

17
18 The AMA has extensive policy in support of debt relief programs, including federal programs such
19 as the National Health Service Corps and Indian Health Service, along with comparable programs
20 from states and the private sector, in that “the costs of medical education should never be a barrier
21 to the pursuit of a career in medicine nor to the decision to practice in a given specialty” (H-
22 305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt”).
23 Additionally, the AMA has numerous policies that address medical schools and the cost of medical
24 education, including tuition and loans. Policy H-305.925(16) states that the AMA will continue to
25 study medical education financing, so as to identify long-term strategies to mitigate the debt burden
26 for medical students. The issue of medical education financial costs was recently studied in Council
27 on Medical Education Report 4-N-21, “Medical Student Debt and Career Choice,” which was
28 adopted at the November 2021 Meeting. While the AMA also advocates for the “development of
29 personal financial literacy capabilities” (D-295.316, “Management and Leadership for
30 Physicians”), there continues to be a need to increase medical students’ financial literacy as they
31 plan for their future. In support of this need, the AMA continues to help individual medical
32 students and physicians gain this financial education by offering medical school debt management
33 solutions through [Laurel Road](#) as well as other [loans and financial services](#).

34
35 The Council on Medical Education therefore recommends that the following recommendations be
36 adopted in lieu of Resolution 306-A-22 and the remainder of this report be filed:

- 37
38 1. That Policy D-305.952, “Medical Student Debt and Career Choice,” be reaffirmed. (Reaffirm
39 HOD Policy)
- 40
41 2. That Policy H-305.925, “Principles of and Actions to Address Medical Education Costs and
42 Student Debt,” be amended by addition of a new point (23), to read “(23) continue to monitor
43 opportunities to reduce additional expense burden upon medical students including reduced-
44 cost or free programs for residency applications, virtual or hybrid interviews, and other cost-
45 reduction initiatives aimed at reducing non-educational debt.” (Amend HOD Policy)
- 46
47 3. That our AMA encourage medical students, residents, fellows and physicians in practice to
48 take advantage of available loan forgiveness programs and grants and scholarships that have
49 been historically underutilized, as well as financial information and resources available through
50 the Association of American Medical Colleges and American Association of Colleges of
51 Osteopathic Medicine, as required by the Liaison Committee on Medical Education and

- 1 Commission on Osteopathic College Accreditation, and resources available at the federal, state
2 and local levels. (New HOD Policy)
3
4 4. That Policy D-305.984 (5), "Reduction in Student Loan Interest Rates," be rescinded, as having
5 been fulfilled by this report:
6
7 ~~"Work with appropriate organizations, such as the Accreditation Council for Graduate Medical
8 Education and the Association of American Medical Colleges, to collect data and report on
9 student indebtedness that includes total loan costs at completion of graduate medical education
10 training."~~ (Rescind HOD Policy)

Fiscal note: minimal

APPENDIX: RELEVANT AMA POLICIES

Principles and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid

employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United

States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

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

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;

7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for-profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

Reduction in Student Loan Interest Rates D-305.984

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced

efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

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

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

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Management and Leadership for Physicians, D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, "Management and Leadership for Physicians," on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 03-A-23

Subject: Financial Burdens and Exam Fees for International Medical Graduates
(Resolution 305-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 At the 2022 Annual Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD), Resolution 305-A-22 was introduced by the Resident and Fellow Section. It asks:
3

4 That our American Medical Association work with all relevant stakeholders to reduce
5 application, exam, licensing fees and related financial burdens for international medical
6 graduates (IMGs) to ensure cost equity with U.S. MD and DO trainees (Directive to Take
7 Action); and be it further
8

9 That our AMA amend current policy [H-255.966](#), “Abolish Discrimination in Licensure of
10 IMGs,” by addition to read as follows:

11 2. Our AMA will continue to work with the FSMB to encourage parity in licensure
12 requirements, and associated costs, for all physicians, whether U.S. medical school
13 graduates or international medical graduates. (Modify Current HOD Policy)
14

15 Testimony on this item noted concern for an unintended consequence that could stimulate debate
16 on the total costs of medical education, of which licensing fees constitute a small portion. The
17 Council on Medical Education offered substitute language for the first resolve, asking the AMA to
18 study the most equitable approach to achieving parity between U.S. MD and DO trainees and
19 international medical graduates with regard to application, exam, and licensing fees and related
20 financial burdens; the Council also suggested that the second resolve not be adopted. The
21 Reference Committee supported study and encouraged the Council to consider the presence and
22 nature of varying application and examination costs for U.S. medical graduate and IMG applicants.
23 The HOD agreed, and this item was referred for study.
24

25 This report is a result of that referral. It aims to explain the steps an IMG must take to practice in
26 the U.S. and related financial burdens to obtaining the ability to practice in the U.S., compare these
27 IMG costs to that of non-IMG MD and DO trainees, and offer recommendations to address cost
28 disparities.
29

30 BACKGROUND

31 An international medical graduate (IMG) is defined as a “physician who received a basic medical
32 degree from a medical school located outside the United States and Canada that is not accredited
33 by a U.S. accrediting body, the Liaison Committee on Medical Education, or the American

1 Osteopathic Association.”¹ It is the location/accreditation of the medical school that determines if
2 the graduate is an IMG (as opposed to the citizenship of the physician). Thus, U.S. citizens who
3 graduated from medical schools outside the United States and Canada are considered IMGs, while
4 non-U.S. citizens who graduated from medical schools in the United States and Canada are not
5 considered IMGs.

6
7 A recent [report](#) from the Council on Medical Education, “Expediting Entry of Qualified IMG
8 Physicians to U.S. Medical Practice” (CME Report 4-J-21) states, “IMGs currently represent a
9 quarter of the physician workforce and physicians-in-training in the United States. They have long
10 been an integral part of the U.S. health care system, contributing substantially to primary care
11 disciplines and providing care to underserved populations, and their foreign language proficiency
12 can be invaluable when communicating with patients from the same country of origin. The
13 diversity of IMGs contributes to the many ethnicities and cultures represented in the health care
14 workforce. This diversity is likely to be a factor enhancing health outcomes, considering the
15 equally diverse nature of the U.S. patient population.”²

16
17 Further, this Council report indicates that compared with U.S. medical school graduates, IMGs
18 provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain
19 states and specialties disproportionately depend on these physicians. These physicians play a
20 critical role in providing health care in areas of the country with higher rates of poverty and chronic
21 disease. Many IMGs have been practicing at institutions that are on the front line of the COVID-19
22 pandemic. The Health Resources and Services Administration (HRSA) offers a [map](#) of Medically
23 Underserved Areas/Populations (MUA/P). The Association of American Medical Colleges
24 (AAMC) State Physician Workforce Data [Report](#) provides related information.

25
26 While the intent of this report is to address application, exam, and licensing fees and related
27 financial burdens for IMGs as compared to U.S. medical school trainees, it is important to note that
28 U.S. trainees incur costs that IMGs may not. For example, the cost to maintain Liaison Committee
29 on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA) and
30 Accreditation Council for Graduate Medical Education (ACGME) accreditation may be passed
31 onto U.S. trainees in their medical school tuition. This is a cost not borne by foreign medical
32 schools, although they may also have accreditation costs related to their own countries.

33 34 DISCUSSION

35
36 The pathway to medical licensure in the U.S. for all trainees involves many steps with specific
37 timelines and deadlines. For IMGs, it is even more complicated. Some IMGs have attended private
38 medical schools outside the U.S., while others have attended public medical schools, resulting in
39 varied costs. Further, there have been problems with credentialing and primary source verification
40 from some countries. The Council on Medical Education has authored a report for the Annual 2023
41 meeting addressing these challenges for IMGs resulting from international conflict that will
42 provide more detail on these issues.

43
44 Before addressing the cost differences between IMGs vs U.S. medical school graduates, it is
45 important to note that costs between MD and DO applicants to GME programs also vary. This
46 problem was recently addressed in an AMA [issue brief](#) entitled “Single Pathway to Licensure.” In
47 addition, there are further cost differences for IMGs. For example, the United States Medical
48 Licensing Examination® (USMLE®) Steps 1 and 2 cost IMGs [\\$1,000](#)³ per exam, versus [\\$660](#)⁴ for
49 MD students and [\\$715](#)⁵ for DO students. IMGs also pay international surcharges related to Steps 1
50 and 2 as well as application and certification fees from Educational Commission for Foreign

1 Medical Graduates (ECFMG, a member of Intealth). See Appendix A for a more detailed review of
2 this information.

3
4 The Federation of State Medical Boards (FSMB) provides a useful [visual aid](#) illuminating the
5 pathway to licensure for U.S. MD and DO students and IMGs; it also includes definitions of the
6 various related organizations, their acronyms, and links to their websites. In addition to these
7 required steps outlined in the FSMB guide, there are many associated costs, including exam
8 preparations and travel. When it comes to licensure, there is cost variance across states,
9 independent of U.S. medical graduate or IMG status. Additionally, there may be different threshold
10 qualifications for IMGs that could have their own costs⁶ along with additional steps for IMGs. For
11 example, Michigan requires IMGs seeking licensure by endorsement to have an existing license
12 from another U.S. jurisdiction. North Carolina and New York require IMGs to have a profile set up
13 with the FSMB Federation Credentials Verification Service.⁷

14
15 Appendix A has further detail as to the costs of the steps necessary to pursue medical education and
16 training, as well as additional associated costs and how they vary among MD students, DO
17 students, and IMGs. Besides the steps described in this Appendix, non-U.S. citizen IMGs undergo
18 additional hurdles that U.S. citizen MD and DO students do not, such as visa applications for non-
19 citizens and tests of English language proficiency.

20 21 *Visa process and barriers*

22
23 Approximately 50 percent of IMGs in GME are U.S. citizens or permanent residents.⁸ The
24 remaining IMGs need to obtain a visa to enter the U.S. to train and/or practice medicine. This is
25 also true for the 0.6 percent of students in U.S. medical schools that are non-U.S. citizens.⁹ For
26 non-citizen medical school graduates, the following protocols must be accomplished:

- 27 • The U.S. employer must obtain foreign labor certification from the [U.S. Department of](#)
28 [Labor](#) (DOL), prior to filing a petition with [U.S. Citizenship and Immigration Services](#)
29 (USCIS).
- 30 • The [USCIS](#) must approve the petition or application (The required petition or application
31 depends on the visa category applied for).
- 32 • The program approval must be entered in the Student and Exchange Visitor Information
33 System (SEVIS) of the [U.S. Immigration and Customs Enforcement](#) (ICE).

34
35 Foreign physicians can work in the U.S. on four major types of [visas](#): H-1B, J-1, O-1, and TN; the
36 J-1 Exchange Visitor program and the H-1B Temporary Worker classification are the most
37 common. The AMA's IMG [toolkit](#) provides additional information to understand the types of visas.
38 Once obtained, all visas need to be renewed for the duration of residency and fellowship training,
39 and each visa type has a different renewal schedule.

40
41 In addition to the challenges and costs of the visa application process, there have been recent
42 political changes and public health emergencies that have caused further delays and compounded
43 expenses. For example, on Jan 27, 2017, former President Donald J. Trump signed an [executive](#)
44 [order](#), "Protecting the Nation from Foreign Terrorist Entry into the United States," that resulted in
45 travel bans impacting many IMGs and their ability to travel to the U.S. The AMA raised its
46 [concerns](#) to the Department of Homeland Security and others, given the detrimental impact on the
47 health care workforce and access to care. During his first day in office, President Biden issued a
48 [proclamation](#) on "Ending Discriminatory Bans on Entry to The United States" to revoke his
49 predecessor's Executive Order. Also, the COVID-19 pandemic impacted many IMGs by causing
50 additional delays in travel and the processing of documents that affected their ability to start their
51 residency, continue their training or practice, or transition from training to practice. On January 25,

1 2021, President Biden issued a [proclamation](#) on “the Suspension of Entry as Immigrants and Non-
2 Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease.”
3 The Council on Medical Education has been attentive to such issues, with related reports released
4 in 2010 and 2017, “Rationalize Visa and Licensure Process for IMG Residents” ([CME 11-A-10](#))
5 and “Impact of Immigration Barriers on the Nation’s Health” ([CME 3-I-17](#)).
6

7 *English language proficiency*

8

9 Since the removal of the Clinical Skills exam component of the USMLE, IMGs are now required to
10 prove their ability to communicate effectively in English by passing the [Occupational English Test](#)
11 (OET). The OET is an English language test designed for health care professionals, owned by
12 Cambridge Assessment English and the Box Hill Institute. OET has been developed to cover 12
13 different health care professions, including medicine. The test assesses language skills in listening,
14 reading, writing, and speaking, utilizing typical communication scenarios from the health care
15 industry. OET is recognized by health care organizations, hospitals, universities, boards, and
16 councils across the world including the U.S. Passing the OET is a requirement for certification by
17 ECFMG for all IMGs, regardless of country of origin and currently costs [\\$455](#)¹⁰; see Appendix A.
18

19 *Key stakeholders*

20

21 The [ECFMG](#) provides IMGs with the process for certification before they enter U.S. GME. This
22 certification is a requirement for IMGs to take Step 3 of USMLE and to obtain an unrestricted
23 license to practice medicine in the U.S. ECFMG programs and web services assist IMGs with the
24 visa process, applying for GME, and verification services to obtain primary-source verification of
25 credentials.

26 The [Federation of State Medical Boards](#) (FSMB) supports the state and territorial medical boards in
27 the U.S. that license, discipline, and regulate physicians and other health care professionals. This
28 includes exam services related to USMLE Step 3 and the Special Purpose Examination (SPEX[®]),
29 as well as credentialing and licensure services. According to the FSMB, SPEX is an examination of
30 “current knowledge requisite for the general, undifferentiated practice of medicine. State boards
31 may require SPEX for endorsement of licensure, reinstatement of a license, or reactivation of a
32 license after a period of inactivity.”¹¹ The FSMB has developed a useful [table](#) of state-by-state
33 information regarding licensure of IMGs, updated in August 2022.
34

35 American Medical Association

36

37 The AMA advocates at the [federal](#) and [state](#) levels to inform, guide, and generate support for
38 policies that advance initiatives addressing the concerns most relevant to all physicians. Examples
39 of current initiatives relevant to IMGs include supporting the [Conrad 30](#) waiver program,
40 advocating to Congress about the importance of IMGs in the physician workforce, and vetting
41 legislation and monitoring regulations related to IMGs. At the 2023 AMA Advocacy Agenda
42 webinar in January, hosted by the Board of Trustees, AMA staff leaders spoke to the importance of
43 advancing bills to support IMGs.
44

45 The AMA’s [International Medical Graduates Section](#) (IMGS) advocates for issues that impact
46 IMGs, provides resources and assistance, and gives voice and representation to IMGs in the AMA
47 House of Delegates. Resources for IMGs from the section include toolkits, FAQs, and a listing of
48 observership programs, as well as policy and advocacy opportunities.

49 In 2022, the Council on Medical Education published an [issue brief](#), “Support for IMGs practicing
50 in the US,” which addresses potential alternative pathways for licensure for IMGs from select
51 countries including recognition of residency training outside the United States with completion of

1 at least one year of graduate medical education in an accredited U.S. program and unfettered travel
2 for IMGs for the duration of their legal stay in the U.S. in order to complete their residency or
3 fellowship training to prevent disruption of patient care.

4 5 RELEVANT AMA POLICIES

6
7 The AMA has a number of policies that demonstrate strong support for IMGs during and after
8 training, as well as for those who do not match, as provided in Appendix B. For example:

- 9 • Policy [H-255.988](#), “AMA Principles on International Medical Graduates,” lists the AMA’s
10 position on key IMG issues.
- 11 • Policy [H-255.966](#), “Abolish Discrimination in Licensure of IMGs,” encourages the FSMB
12 and state medical boards to evaluate the progress of programs aimed at reducing barriers to
13 licensure—including successes, failures, and barriers to implementation.
- 14 • Policy [D-310.977](#), “National Resident Matching Program Reform,” encourages the
15 ECFMG and other interested stakeholders to study the personal and financial consequences
16 of ECFMG-certified U.S. IMGs who do not match.

17 18 SUMMARY AND RECOMMENDATIONS

19
20 IMGs face costly and time-consuming steps in their pursuit of U.S. medical training, licensure and
21 practice that are not required of their U.S. MD and DO counterparts. These costs can present
22 barriers and delays to their training and practice that impact IMGs, their training programs and
23 employers, and possibly the health of patients who rely on them for care. Key stakeholders,
24 including the AMA, recognize the additional challenges IMGs face and have been engaged in
25 assisting IMGs in meeting these challenges. The AMA continues to be engaged in such efforts.

26
27 The Council on Medical Education therefore recommends that the following recommendations be
28 adopted in lieu of Resolution 305-A-22, and the remainder of this report be filed:

- 29
30 1. That our American Medical Association (AMA) encourage key stakeholders, such as the
31 National Board of Medical Examiners, Federation of State Medical Boards, Educational
32 Commission for Foreign Medical Graduates (a member of Intealth), Cambridge
33 Assessment English and Box Hill Institute, and others to (a) study the most equitable
34 approach for achieving parity across U.S. MD and DO trainees and international medical
35 graduates with regard to application, exam, and licensing fees and related financial
36 burdens; and (b) share this information with the medical education and IMG communities.
37 (Directive to Take Action)
- 38
39 2. That our AMA encourage relevant stakeholders to work together to achieve cost
40 equivalency for exams required of all medical students and trainees, including IMGs.
41 (Directive to Take Action)
- 42
43 3. That AMA policy [H-255.988](#), “AMA Principles on International Medical Graduates,” be
44 reaffirmed. (Reaffirm HOD Policy)

45
46
47 Fiscal note: \$1,000

APPENDIX A

Medical Education steps and associated costs, 2022-2023

Requirement	MD	DO	IMG	Associated costs
Undergraduate program (average 4 years)	Tuition, books, and related fees. Completion of bachelor's degree, inclusive of prerequisite courses.		<ul style="list-style-type: none"> Some countries offer undergraduate programs at no cost. Some countries allow students to go directly to medical school after high school (i.e., no undergraduate). 	Expenses related to travel, housing, meals, health care.
Medical College Admissions Test® (MCAT®)	\$330 standard fee \$135 FAP* fee \$120 nonrefundable international fee (for examinees testing outside the U.S., Canada, or U.S. Territories; in addition to the standard fee).		N/A	Expenses related to test preparation tools/courses
Occupational English Test® (OET)	None	None	\$455 ^d	Expenses related to test preparation, travel, lodging, etc.
Primary medical school application fee	American Medical College Application Service® (AMCAS®): \$170 first school and \$43 for each additional school. Some schools do not use AMCAS.	American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS): \$198 first school and \$50 for each additional school.	N/A	Expenses related to application preparation tools, college service fees (e.g., transmit transcript and/or letters of recommendation.
Secondary application fee	Average \$50-100 per school		N/A	

<p>Access to database about medical schools</p>	<p>Many applicants purchase a subscription to Medical School Admission Requirements® (MSAR®) database to learn detailed information about allopathic medical schools. \$28 for one-year, \$36 for 2 years. Free for FAP*.</p>	<p>The free Choose DO Explorer allows applicant to learn detailed information about osteopathic medical schools.</p>	<p>N/A</p>	
<p>Medical school interviews</p>	<p>Costs may vary depending on whether the interview is virtual or in person. If in person, costs include mode of travel, lodging, attire, and meals per interview location. Costs for virtual interviews include the cost of internet access and the use of a computer or other electronic device.</p>			
<p>Medical school (average 4 years)</p>	<p>Tuition, books, and related fees — inclusive of medical school costs to achieve LCME accreditation.</p>	<p>Tuition, books, and related fees — inclusive of medical school costs to achieve COCA accreditation.</p>	<p>Tuition, books, and related fees — may include medical school costs to achieve accreditation.</p>	<p>Expenses related to travel, housing, meals, health care.</p>
<p>USMLE Step 1/ COMLEX-USA Level 1</p>	<p>\$660⁴</p>	<p>\$715⁵</p>	<ul style="list-style-type: none"> • \$1,000³: exam fees for Step 1 and Step 2 for each exam registration. • \$195: Step 1 International Test Delivery surcharge. • \$220: Step 2 CK International Test Deliver Surcharge. 	<p>Expenses related to preparation tools for the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), extension of eligibility period, rescheduling fee, score recheck, transcript, etc.</p>
<p>USMLE Step 2 CK/ COMLEX-USA Level 2-CE</p>	<p>\$660⁴</p>	<p>\$715⁵</p>	<p>Additional fees for ECFMG exam chart, Clinical Skills Assessment (CSA) history chart.</p>	<p>Expenses related to preparation tools for the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), extension of eligibility period, rescheduling fee, score recheck, transcript, etc.</p>

USMLE Step 3/ COMLEX-USA Level 3	\$915	\$910	\$915 (USMLE Step 3 required for training/practice in US).	
Application for Pathway for ECFMG certification for Match	None	None	\$925 Note: Canadian medical school graduates do not need to obtain ECFMG certification since the schools are LCME accredited until June 30, 2025. After such time, graduates will have to be ECFMG certified.	\$250 medical school transcript.
ECFMG certification	None	None	\$160	\$370 annual application fee for J-1 Visa waiver sponsorship for non-U.S. citizens or permanent residents. Additional \$220 SEVIS fee, payable to the Department of Homeland Security, is required of initial applicants for J-1 sponsorship.
Application for licensure in state(s) of intended practice	Licensure requirements for domestic and international medical graduates differ between the states.			Expenses related to proof of education, training and licensure exam completion, dues structure, maintenance of licensure, continuing medical education.
Electronic Residency Application Services® (ERAS®)	<ul style="list-style-type: none"> • \$99 (up to 10 programs) • \$19 each (11-20) • \$23 each (21-30) • \$26 each (31 or more) 			\$165 ERAS token, \$80 transcript assessment.

Residency (average 3-7 years)	Varies	Varies Note: All state licensing jurisdictions require a graduate of a foreign medical school to complete at least one year of accredited U.S. or Canadian graduate medical education before licensure.	Expenses related to relocation, travel, housing.
ABMS board certification	Member board certification exam fees vary per board. Some physicians may pursue more than one board.		Expenses related to proof of medical degree from a qualified medical school, completion of 3-5 years of full- time experience in an ACGME- accredited residency program, unrestricted medical license to practice in the U.S. or Canada, continuing board certification and/or recertification.
Fellowship (average 1-3 years)	Varies		Expenses related to relocation, travel, housing.
Credential verification for practice	Many employers require proof of credentials.		

*The AAMC [Fee Assistance Program](#) (FAP) assists those who, without financial assistance, would be unable to take the Medical College Admission Test® (MCAT®), apply to medical schools that use the American Medical College Application Service® (AMCAS®), and more. Participation in this program may decrease or eliminate fees above. AACOM has a similar program called [Fee Waiver Program](#).

APPENDIX B

Relevant AMA Policy

H-255.988, AMA Principles on International Medical Graduates

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for

outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

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

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

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

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

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

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

23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.

25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

H-255.966, Abolish Discrimination in Licensure of IMGs

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

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

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

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

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

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

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

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

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

5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

D-310.977, National Resident Matching Program Reform

Our AMA:

(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;

(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;

(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;

(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;

(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;

(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency

spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Additional IMG policies:

[H-255.978, Unfair Discrimination Against International Medical Graduates](#)

[D-295.988\(3a-c\), Clinical Skills Assessment During Medical School](#)

[D-255.991, Visa Complications for IMGs in GME](#)

[D-255.977, Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses](#)

[D-275.950, Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association](#)

[H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools](#)

[D-255.985, Conrad 30 - J-1 Visa Waivers](#)

[D-295.960, Clinical Skills Training in Medical Schools D-295.960](#)

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REPORT 04 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Decreasing Bias in Assessments of Medical Student Clinical Clerkship
Performance (Resolution 309-A-22, Resolve 2)
(Reference Committee C)

EXECUTIVE SUMMARY

Per a directive from the House of Delegates (HOD), the American Medical Association (AMA) has been asked to study and report back on the impact of two-interval clinical clerkship grading systems on residency application outcomes, clinical performance during residency, and bias.

This report defines two-interval grading (binary pass/fail with no other hierarchical ranking) and notes existing policy regarding pass/fail in non-clinical curricula. This report offers the theoretical background for the importance of pass/fail grading within competency-based medical education and formative assessment. It also highlights the competitive medical education system and the ongoing demand for summative assessment and ranking, particularly due to applicant selection challenges impacting both learners and program directors.

Due to a need for additional future research combining the multiple factors indicated by the HOD's directive, this report instead summarizes research on each relevant topic individually, including significant variability and bias within clinical clerkship grading; existing recommendations toward improving reliability in this area; background on how grading system data is collected; proportions of two-interval pass/fail grading systems across medical schools; and current overall research on residency application outcomes, longitudinal performance tracking, and bias issues. This report emphasizes the diverse factors and potential unintended consequences that may arise when hierarchy is eliminated in one area of medical education and ranking decisions are shifted to other areas.

This report proposes reaffirmation of current AMA policy and offers new recommendations that continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition"; encourage and support UME institutions' investment in a) developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and b) providing standardized and meaningful competency data to program directors; encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias; and encourage UME institutions to include grading system methodology with grades shared with residency programs.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 04-A-23

Subject: Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 Resolution 309-A-22, “Decreasing Bias in Evaluations of Medical Student Performance,” was
2 introduced by the Medical Student Section at the 2022 Annual Meeting of the American Medical
3 Association (AMA). While Resolve 1 was adopted into AMA Policy [D-295.307](#), Resolve 2 was
4 referred for study. The referred clause asked that our AMA:

5
6 Study the impact of two-interval clinical clerkship grading systems on residency application
7 outcomes and clinical performance during residency.
8

9 Testimony emphasized the current difficulty in accessing data needed to inform such a study and
10 work underway via the AMA ChangeMedEd initiative toward longitudinal tracking. Testimony
11 also highlighted challenges faced by program directors, the delicate balance of wanting more data
12 versus ensuring unbiased data, and equity concerns regarding current grading models and diverse
13 learners. Reference Committee C and the House of Delegates (HOD) felt that these concerns
14 warranted further study. This report is in response to this referral.
15

16 BACKGROUND

17 *Clinical Clerkships and Two-Interval Grading*

18
19
20 In clinical clerkships, medical students are immersed in learning experiences involving direct
21 patient care and application of clinical sciences.¹ This comprises both core and elective rotations,
22 beginning in the third year of medical school, and with significant variability between clerkship
23 experiences based on seasonal infectious disease cycles, electives chosen, and other considerations.
24

25 Two-interval grading refers to grading structures with only two options, either pass or fail, though
26 these grades may also be accompanied by narrative information. Two-interval pass/fail grading is
27 distinct from generalized pass/fail grading insofar as some pass/fail grading structures offer
28 opportunities for grading with honors and other hierarchies, such as “high pass,” as opposed to the
29 binary pass/fail. While AMA Policy [H-295.866](#), “Supporting Two-Interval Grading Systems for
30 Medical Education,” encourages “the establishment of a two-interval grading system in medical
31 colleges and universities in the United States for the non-clinical curriculum,” current policy does
32 not address clinical curriculum.
33

34 *Competency-Based Medical Education and the “Growth Mindset”*

35
36 The current rationale for two-interval grading centers around learner trust and growth within the
37 move toward competency-based medical education, or CBME (see also AMA policy [D-295.317](#)).

1 Specifically, for medical education to focus on outcomes via a developmental approach,
2 vulnerability for learners must be acknowledged and institutional culture must demonstrate
3 trustworthiness, as learner gaps and needs may only be addressed if acknowledged rather than
4 hidden due to performance pressure.² Thus, two-interval pass/fail frees the learner from striving for
5 a specific performative grade, allowing more transparency around gaps. This redirects focus to
6 effectively meeting required competencies (passing) after careful consideration of areas for
7 improvement, rather than concealing difficulties to rank higher. Equity between learners is
8 complex and not inherently achieved by grading system changes alone, as discussed in later
9 sections. Biases related to race, gender, disability, or other factors exist in a wider societal
10 structure, and interventions require a multi-pronged approach.³ However, even highly rigorous and
11 non-biased assessments would drive undesired behaviors (concealment versus transparency toward
12 growth) if graded or ranked.⁴ Nonetheless, larger medical education and societal structures
13 currently create a demand for ranking, as discussed below.

14 15 *Applicant Selection Challenges*

16
17 A significant concern regarding possible elimination of tiered rankings in clerkship grades involves
18 the increasing number of residency applications and growing challenges for programs when
19 selecting from an overwhelming number of candidates. The United States Medical Licensing
20 Examination[®] (USMLE[®]) Step 1 examination's shift to pass/fail in January 2022 sparked concerns
21 in this regard from residency program directors: a study of internal medicine program directors
22 found that, in the absence of graded Step 1 examination scores, program personnel would be
23 increasingly likely to weight such variables as ranked clerkship grades, Step 2 exam scores,
24 personal knowledge of the applicant, and audition electives; respondents also expressed the belief
25 that osteopathic applicants may potentially be further disadvantaged.⁵ Data regarding actual impact
26 is unknown because not enough time has passed. Without an overhaul of the application process
27 and infrastructure supportive of the time necessary for holistic review of applicants⁶ or transition
28 away from competition-based processes (i.e., randomization via lottery), eliminating rankings in
29 certain areas may indeed pose challenges. However, clerkship grades are an unreliable measure for
30 evaluating residency applicants and challenged by inconsistencies and bias, as further described in
31 the next section.

32 33 *Unreliability and Variability in Clinical Clerkship Grades*

34
35 Despite perceptions of their importance in selecting program applicants, clinical clerkship grades
36 are generally found to be inconsistent and unreliable.⁷ In one study, most students believed that
37 clerkship grades were unfair and that being liked by specific supervisors most influenced grading⁸;
38 further data confirms the detachment of clerkship grades from useful assessment criteria. One study
39 noted that most medical schools used a four-tier system of fail, pass, high pass, or honors, but all
40 defined these words subjectively and inconsistently, even within the same programs; this variability
41 across schools and even within programs poses a challenge to accurate stratification of applicants.⁹
42 U.S. News & World Report Top 20 medical schools were also more likely to disproportionately
43 assign the highest clerkship grade to a higher percentage of students than other medical schools,¹⁰
44 even though these schools were also less likely to implement grade comparison at all.¹¹ Clerkship
45 grades often suggest the "illusion of objectivity," despite no standard approach to assigning grades
46 or rank, flawed data not based on actual observations, high stress for students, and time-based
47 grading paradigms that promote inequities.¹²

48 49 *Equity and Diversity Concerns Within Medical School Assessment*

50

1 Beyond concerns of general unreliability, equity and diversity concerns also arise within clinical
2 clerkship assessment. One 2018 study (which defined “underrepresented in medicine” narrowly as
3 students from the racial or ethnic groups Black, Latina/o/x, Native American, and Alaska Native)
4 demonstrated differences in clerkship director ratings that consistently favored non-
5 underrepresented students, and while these differences were small, they created an amplification
6 cascade later in the educational experience, compounding challenges already faced by these
7 students due to structural racism.¹³ Another 2019 study demonstrated that, even after accounting
8 for confounding variables, grades were more likely to favor white students above both
9 underrepresented and non-underrepresented students of color.¹⁴ Even prior to grading itself, the
10 training environment and overall social environment already hinders students from marginalized
11 racial/ethnic groups, depleting cognitive resources and interfering with learning,¹⁵ such that even
12 with more “objective” grading standards, societal bias already creates an inequitable environment
13 for learning. Finally, while research that addresses the specific topic of clinical clerkship
14 assessment for other marginalized identities/experiences is limited, learners are subjected to
15 systemic biases in many realms, such as LGBTQ issues,¹⁶ socioeconomic status¹⁷, and disability.¹⁸

16 DISCUSSION

17
18
19 Course grades perform two purported functions: giving students a summative evaluation of their
20 course performance and providing a standardized means of communicating student performance to
21 third parties. Grades should be distinguished from formative assessments, which are focused on
22 improving student learning. As a summative evaluation, grades should be based on valid and
23 reliable data and contain sufficient information to be useful to students and third parties, with
24 attention to the ways larger systemic bias and inequitable assignment of merit influences even
25 otherwise reliable data.¹⁹ Current data demonstrated above indicates significant reliability concerns
26 in current grading systems.

27
28 Little data exists to demonstrate the impact of two-interval clinical clerkship grading on residency
29 application outcomes and clinical performance during residency, and even less data that includes
30 analysis by race, gender, socioeconomic class, disability, or other relevant demographics. This
31 report seeks to split the question into its various components, provide background on how some
32 data is collected and reported, offer currently available research, and offer suggestions on how this
33 data might be gathered in the future.

34 35 *Current Data and Challenges Regarding Pass/Fail in Clinical Clerkships*

36
37 Much current research suggests that two-interval pass/fail grading systems improve learner well-
38 being in the preclinical years,²⁰ and academic performance remains similar, with an increased
39 opportunity for a reduction of stress and less competitive learning environment.²¹ Proponents of
40 CBME also generally advocate to reframe two-interval pass/fail as two-interval “only pass/not yet
41 pass” and to utilize criterion-referenced assessment such that learners will pass in time.²² Support
42 for CBME is inherently linked to removing hierarchical grading structures in all aspects of medical
43 education.²³

44
45 Data around usage of pass/fail grading systems in clinical clerkships is collected by the Liaison
46 Committee on Medical Education (LCME) for allopathic schools and by the American Association
47 of Colleges of Osteopathic Medicine (AACOM) for osteopathic schools, but few analyses of
48 impact exist.

49
50 The LCME’s files indicated the following data for each portion of the curriculum:

LCME Part II Totals: Type of Grading System Used (2019-2020)			
Grading system	Required clinical clerkships	Fourth-year selectives/sub-internships	Electives
Pass-fail	11	32	84
Honors-pass-fail	26	27	21
Honors-high pass-pass-fail	85	68	57
Numerical grade	6	1	0
Letter grade	24	19	10
Other	13	8	7

LCME Part II Totals: Type of Grading System Used (2020-2021)			
Grading system	Required clinical clerkships	Fourth-year selectives/sub-internships	Electives
Pass-fail	24	37	92
Honors-pass-fail	25	27	22
Honors-high pass-pass-fail	81	72	54
Numerical grade	7	4	7
Letter grade	20	18	9
Other	11	10	12

LCME Part II Totals: Type of Grading System Used (2021-2022)			
Grading system	Required clinical clerkships	Fourth-year selectives/sub-internships	Electives
Pass-fail	20	37	90
Honors-pass-fail	26	27	18
Honors-high pass-pass-fail	82	73	55
Numerical grade	3	0	0
Letter grade	19	15	10
Other	9	8	10

1 As seen above, within required clinical clerkships, two-interval pass/fail accounted for only about
2 seven percent of grading systems in 2019-2020 and 14 percent in 2020-2021, with a slight decline
3 in 2021-2022 to 20 schools out of 155, or about 13 percent. In fourth-year medical selective
4 rotations, two-interval pass/fail grading systems accounted for about 21 percent in 2019-2020, 22
5 percent in 2020-2021, and 23 percent in 2021-2022. Elective clerkships were more likely to be
6 two-interval pass/fail than other clerkships, as this accounted for about 47 percent of grading
7 systems in both 2019-2020 and 2020-2021, and about 49 percent in 2021-2022.

8
9 The most recent AACOM data available showed that 28 schools used pass/fail to grade required
10 clinical clerkships, while 21 schools used pass/fail for elective/selective grading.²⁴ However, this
11 data reflects multi-interval pass/fail variants including honors and does not indicate which, if any,
12 use two-interval grading. Looking closer, a 2020 study of transcripts indicated that osteopathic
13 medical schools' grading system distribution in clinical years was 59.5 percent honors, 29.7
14 percent letter grade, and 10.8 percent other systems. Only one of the 37 osteopathic medical

1 schools participating in this study used two-interval pass/fail systems without tiered indicators such
2 as “high pass” in the clinical years.²⁵ This study demonstrated the variability between grading
3 systems, both within and between allopathic and osteopathic schools, and the rarity of two-interval
4 pass/fail in clerkship years.

5
6 Given limited implementation of two-interval pass/fail, research on the impact of this grading
7 mechanism is even more limited. In 2021, faculty from one institution responded to the elimination
8 of tiered clerkship grades with optimism for well-being and the learning environment, as well as
9 hesitations, such as lack of readiness for hierarchies in later educational structures and concerns
10 about the residency selection process.²⁶ Students in a different 2021 qualitative study shared that
11 implementation of two-interval pass/fail core clerkship grading, in combination with enhanced
12 formative feedback, resulted in benefits to intrinsic motivation, increased ability to seek feedback
13 and improvements, lowered stress, and perceived mitigation of equity concerns.²⁷ However, this
14 perceived mitigation was not confirmed with outcomes-based data, nor are these perceptions
15 disaggregated by respondent demographics. In another study from 2022, transitioning to two-
16 interval clinical clerkship grades with enhanced feedback was related to moderate to large
17 improvements in students’ perceptions of grading and the learning environment, toward that of
18 “mastery-oriented learning” rather than performative behavior. Simultaneously, deeper learner
19 concerns around bias in evaluators and inequitable narrative summaries remained.²⁸

20 21 *Current Clinical Clerkship Recommendations for Eliminating Grading Bias*

22
23 Grappling with known equity issues, the Alliance for Academic Internal Medicine’s 2021 report,
24 “Aiming for Equity in Clerkship Grading: Recommendations for Reducing the Effects of Structural
25 and Individual Bias” indicated the scarcity of evidence-based resources for eliminating bias in
26 clinical clerkship grading. Using a socioecological model, the authors suggest several possible
27 interventions for further implementation and study, including but not limited to faculty
28 development, non-normative competency-based grading, and refraining from standardized cut-off
29 scores to designate honors in grading, though recommendations do not explicitly suggest removal
30 of honors within grading.²⁹

31
32 Also regarding systemic bias concerns in grading, the Coalition for Physician Accountability’s
33 Undergraduate Medical Education-Graduate Medical Education Review Committee recommended
34 the following in 2021: “To eliminate systemic biases in grading, medical schools must perform
35 initial and annual exploratory reviews of clinical clerkship grading, including patterns of grade
36 distribution based on race, ethnicity, gender identity/expression, sexual identity/orientation,
37 religion, visa status, ability, and location (e.g., satellite or clinical site location), and perform
38 regular faculty development to mitigate bias. Programs across the UME-GME continuum should
39 explore the impact of bias on student and resident evaluations, match results, attrition, and selection
40 to honor societies.”³⁰

41
42 In 2022, Russo et al. demonstrated the bias present within clinical clerkship grades and suggested
43 that two-interval pass/fail grading as one component may mitigate the impact of bias, though it will
44 not eliminate bias itself. “Shifting to a competence-based assessment model will give the learner
45 multiple opportunities over time to demonstrate their mastery of skills and knowledge, thereby
46 reducing the power of a single biased assessment.”³¹

47
48 Due to the complexities of bias within clinical clerkship grading systems, the need for innovation is
49 clear, but additional evidence is required to understand whether two-interval pass/fail grading
50 effectively addresses these challenges.

51

1 *Current Data and Challenges Regarding Pass/Fail and Residency Application Outcomes*

2
3 When considering how to understand the impact two-interval pass/fail in clinical clerkships may
4 have on residency application outcomes, especially regarding bias and equity, one must first
5 consider what data is needed, and how this data is currently collected.

6
7 Match results from applications to residency programs are reported in aggregate by both the
8 National Resident Matching Program (NRMP) and by medical schools. While it might be possible
9 to determine some correlation between the schools that use two-interval pass/fail in clinical
10 clerkships and their aggregate Match results, all other confounding factors would need to be
11 considered, including other aspects of the school and all other determining factors considered in
12 applications, both on larger-scale and individual learner levels. When also considering learner
13 diversity and any potential impacts of bias, information would need to be disaggregated into
14 multiple categories, such as race, ethnicity, disability, gender identity, sexual orientation,
15 socioeconomic status, and more. Some of this information is currently collected in aggregate ways,
16 such as through the Association of American Medical Colleges' (AAMC) Medical School
17 Graduation Questionnaire,³² but not all aspects of bias are addressed; these results are not tied to
18 specific application outcomes or individuals due to privacy concerns. Further insights on two-
19 interval pass/fail grading systems' impact on bias in residency application outcomes would require
20 the limited number of schools with two-interval pass/fail in clinical clerkship to study this
21 specifically, comparing archival data before two-interval grading with current data, and with a
22 student population large enough to ensure confidentiality for participants. This data would then
23 need to be published. Multiple schools would need to achieve this to provide sufficient numbers to
24 allow for comparison between institutions, and between allopathic versus osteopathic programs.

25
26 Outside of medical schools, in a related field, a 2019 study found that for Doctor of Pharmacy
27 students within advanced pharmacy practice experiences, there was little statistical difference in
28 residency match rates between applicants with two-interval pass/fail grades and tiered grades to
29 assess clinical experiences. However, pharmacy education exists in a different context than medical
30 education, and extrapolations cannot necessarily be made.

31
32 As discussed in earlier sections, it is well-known that bias is a concern in residency application
33 outcomes. A 2019 study found no statistically significant differences in residency application
34 outcomes in one institution when pre-clinical grades are pass/fail,³³ but no such research currently
35 exists for clinical clerkships. Current research merely indicates that clinical clerkship grades overall
36 are not useful for ranking residency applications.³⁴ A 2021 study suggested that receiving honors in
37 clinical clerkship grading contributed to matching into the applicant's top five programs in
38 OB/GYN³⁵ where honors were available, but that minority and male students were less likely to
39 receive honors, suggesting further need for research into grading disparities.

40
41 Residency programs must currently create a rank list of applicants for admission, and in numerous
42 specialties and for many residency programs, the number of qualified applicants to be evaluated
43 greatly exceeds the number of positions available. Medical school clerkship grades are among
44 several factors used by residency programs to determine the ranking of applicants. Though these
45 grades are currently unreliable, as discussed above, conversion to two-interval pass/fail grading
46 systems for clerkships without other interventions will require residency programs to weigh other
47 data points more heavily when reviewing applications, such as recommendation letters or perceived
48 medical school reputation. It is uncertain if these alternative factors are more valid or subject to less
49 bias than clerkship grades, and the impacts on diverse student groups are still uncertain. While
50 further knowledge is gathered, medical schools can invest in improving their grading systems to

1 decrease bias, provide transparency to residency programs regarding their grading system
2 methodologies, and invest in methods of providing more useful information to residency programs.

3 4 *Current Data and Challenges Regarding Longitudinal Tracking into Residency*

5
6 Additional challenges arise when seeking data on how two-interval pass/fail grades in clinical
7 clerkship and bias may impact residency performance outcomes. For longitudinal tracking into
8 residency, current data sources include feedback from program directors to school deans, either
9 sent by the school or coordinated by the AAMC Resident Readiness Survey.³⁶ However,
10 information published by the AAMC does not track comparatively across schools, and even
11 comparative school data would need to account for confounding factors, not merely each school's
12 clinical clerkship grading system. As with application outcome challenges, residency performance
13 outcome challenges also include the need to collect and disaggregate demographic information for
14 learners without violating learner privacy.

15
16 There is currently no pre-existing research to draw from on the direct impact of two-interval
17 pass/fail clinical clerkship grading systems on residency performance outcomes, with or without
18 the consideration of equity and bias. One 2019 study that begins to approach the topic is a meta-
19 analysis of program directors' perceptions of residency performance among residents from schools
20 using two-interval pass/fail versus tiered clerkship grading, which found no significant difference
21 in perceptions of overall performance between these groups.³⁷ However, perceptions of
22 performance do not inherently translate to actual actions taken nor actual criterion-referenced
23 performance and carry the additional limitation of reflecting only on those who were already
24 admitted into residency.

25
26 Some progress has been made on overall development of longitudinal tracking, though not related
27 to these topics specifically. For instance, the AMA Accelerating Change in Medical Education
28 Consortium created a personalized graduate profile for 32 medical schools, addressing three core
29 questions of workforce, clinical exposure, and quality of care. This may serve as "a proof of
30 concept" for further research into the topics of this report.³⁸ The Accreditation Council for
31 Graduate Medical Education (ACGME) also collects milestone data by specialty,³⁹ but this data is
32 not currently compared with data on pass/fail grading systems in clinical clerkships. There is also
33 evidence to suggest that racial and ethnic biases may impact milestone levels. For instance, a 2022
34 study in pediatric programs found race and gender disparities in assessments of trainees in
35 residency programs.⁴⁰

36 37 RELEVANT AMA POLICY

38
39 The AMA has extensive policy related to grading systems and mitigating bias in medical
40 education. Some examples are as follows:

- 41
42
- 43 • [D-200.985](#), "Strategies for Enhancing Diversity in the Physician Workforce," recommends
44 that residency/fellowship programs use holistic assessments of applicants that take into
45 account the diversity of preparation and the variety of talents that applicants bring to their
46 education.
 - 47 • [D-310.945](#), "Mitigating Demographic and Socioeconomic Inequities in the Residency and
48 Fellowship Selection Process," encourages medical schools, medical honor societies, and
49 residency/fellowship programs to work toward ethical, equitable, and transparent recruiting
processes, which are made available to all applicants.

- 1 • [D-295.988](#), “Clinical Skills Assessment During Medical School,” works with appropriate
2 stakeholders to assure the processes for assessing clinical skills are evidence-based and
3 most efficiently use the time and financial resources of those being assessed.
- 4 • [D-295.317](#), “Competency Based Medical Education Across the Continuum of Education
5 and Practice,” continues to study and identify challenges and opportunities and critical
6 stakeholders in achieving a competency-based curriculum across the medical education
7 continuum and other health professions that provides significant value to those
8 participating in these curricula and their patients.
- 9 • [D-295.318](#), “Competency-Based Portfolio Assessment of Medical Students,” develops
10 pilot projects to study the impact of competency-based frameworks on student graduation,
11 the residency match process, and off-cycle entry into residency programs.
- 12 • [D-295.963](#), “Continued Support for Diversity in Medical Education,” works with
13 appropriate stakeholders to commission and enact the recommendations of a forward-
14 looking, cross-continuum, external study of 21st century medical education focused on
15 reimagining the future of health equity and racial justice in medical education.
- 16 • [D-295.307](#), “Decreasing Bias in Evaluations of Medical Student Performance,” works with
17 appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact
18 of bias in medical student performance evaluation as well as reducing the impact of bias in
19 the review of disciplinary actions.
- 20 • [D-295.983](#), “Fostering Professionalism During Medical School and Residency Training,”
21 continues to study the clinical training environment to identify the best methods and
22 practices used by medical schools and residency programs to foster the development of
23 professionalism.
- 24 • [H-350.979](#), “Increase the Representation of Minority and Economically Disadvantaged
25 Populations in the Medical Profession,” supports increasing the representation of
26 minorities in the physician population.
- 27 • [D-295.322](#), “Increasing Demographically Diverse Representation in Liaison Committee on
28 Medical Education Accredited Medical Schools,” studies medical school implementation
29 of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the
30 results with appropriate accreditation organizations and all state medical associations for
31 action on demographic diversity.
- 32 • [H-295.866](#), “Supporting Two-Interval Grading Systems for Medical Education,” works
33 with stakeholders to encourage the establishment of a two-interval grading system in
34 medical colleges and universities in the United States for the non-clinical curriculum.
35

36 These policies are listed in full detail in Appendix A.

37 38 SUMMARY AND RECOMMENDATIONS

39
40 Fair and equitable assessment in medical school improves career opportunities for medical students
41 and benefits the public which deserves a more diverse physician workforce. Grades are one form of
42 summative assessment of student performance, and summative assessment should provide third
43 parties with important information about learner competencies and readiness. Current research
44 demonstrates that despite the weighting of clinical clerkship grades in residency applicant
45 selection, these grades are currently inconsistent, unreliable, and biased. Thus, medical schools
46 should invest in developing valid, reliable, unbiased, and informative assessments for clerkships.
47 Two-interval pass/fail clinical clerkship grading systems are rare in allopathic and osteopathic
48 schools alike, and understanding their impacts on residency application outcomes and clinical
49 performance during residency, especially from an equity lens, will require significant effort by
50 researchers and medical education stakeholders. Efforts toward longitudinal tracking in general are

1 also still in the early stages. However, both AMA policy and pre-existing research do support
2 overall well-being and learning environment improvements related to two-interval pass/fail grading
3 systems in the pre-clinical years. Not all schools have implemented this grading structure, and
4 continued encouragement to do so is warranted.

5
6 Learners, including learners experiencing systemic oppression in one or many domains, are not a
7 monolith, and the need for nuance is paramount as these issues are addressed. Inequity in clinical
8 clerkship assessment may be one symptom of the wider culture of systemic bias as well as a
9 reflection of the current learning environment of competition within medical education. The
10 “bottleneck” within the popularity of certain specialties over others also amplifies the competitive
11 environment. Without a greater shift within medical education’s values, or without tending to the
12 entire landscape of medical education, modifying one component piece may send varying intended
13 and unintended ripple effects outwards to the other components of learner assessment—potentially
14 shifting pressure and bias from one area to another, and having unknown and heterogeneous effects
15 on a variety of learners. It is difficult to assess only one piece of the overall system to reflect an
16 understanding of overall equity in assessment, and even more challenging to correct only one piece
17 of a much wider puzzle. Despite these challenges, further gathering of data and the exploration of
18 innovations across the continuum of medical education is beneficial, with an emphasis on attention
19 to the needs of unique populations, especially those that are underrepresented in medicine or
20 experience bias. An evidence base for best practices and interventions can and should be gathered.
21 Strategies must focus on the wider whole, including evaluating the benefits and challenges of
22 moving to a competency-based system with equity at the forefront, rather than a time-based and
23 competitive system.

24
25 The Council on Medical Education therefore recommends that the following recommendations be
26 adopted in lieu of Resolution 309-A-22, Resolve 2, and the remainder of this report be filed:

27
28 That our American Medical Association (AMA):

- 29
30 1. Continue to encourage work in support of the Coalition for Physician Accountability’s
31 Undergraduate Medical Education-Graduate Medical Education Review Committee
32 “Recommendations for Comprehensive Improvement of the UME-GME Transition.”
33 (Directive to Take Action)
34
35 2. Encourage and support UME institutions’ investment in a) developing more valid, reliable,
36 and unbiased summative assessments for clinical clerkships, including development of
37 assessors’ awareness regarding structural inequities in education and wider society, and b)
38 providing standardized and meaningful competency data to program directors. (New HOD
39 Policy)
40
41 3. Encourage institutions to publish information related to clinical clerkship grading systems
42 and residency match rates, with subset data for learners from varied groups, including
43 those that have been historically underrepresented in medicine or may be affected by bias.
44 (New HOD Policy)
45
46 4. Encourage UME institutions to include grading system methodology with grades shared
47 with residency programs. (New HOD Policy)
48
49 5. Reaffirm the following policies:
50
51 • [D-295.307](#), “Decreasing Bias in Evaluations of Medical Student Performance”

- 1 • [H-295.866](#), “Supporting Two-Interval Grading Systems for Medical Education”
- 2 • [D-295.317](#), “Competency Based Medical Education Across the Continuum of Education
- 3 and Practice”
- 4 • [D-295.318](#), “Competency-Based Portfolio Assessment of Medical Students”

5
6
7 Fiscal note: TBD

8
9 APPENDIX A: RELEVANT AMA POLICY

10
11 Strategies for Enhancing Diversity in the Physician Workforce D-200.985

- 12 1. Our AMA, independently and in collaboration with other groups such as the Association of
13 American Medical Colleges (AAMC), will actively work and advocate for funding at the federal
14 and state levels and in the private sector to support the following: (a) Pipeline programs to prepare
15 and motivate members of underrepresented groups to enter medical school; (b) Diversity or
16 minority affairs offices at medical schools; (c) Financial aid programs for students from groups that
17 are underrepresented in medicine; and (d) Financial support programs to recruit and develop
18 faculty members from underrepresented groups.
- 19 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and
20 similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity
21 Program, Area Health Education Centers, and other programs that support physician training,
22 recruitment, and retention in geographically-underserved areas.
- 23 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce,
24 including engaging in broad-based efforts that involve partners within and beyond the medical
25 profession and medical education community.
- 26 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical
27 schools demonstrate compliance with its requirements for a diverse student body and faculty.
- 28 5. Our AMA will develop an internal education program for its members on the issues and
29 possibilities involved in creating a diverse physician population.
- 30 6. Our AMA will provide on-line educational materials for its membership that address diversity
31 issues in patient care including, but not limited to, culture, religion, race and ethnicity.
- 32 7. Our AMA will create and support programs that introduce elementary through high school
33 students, especially those from groups that are underrepresented in medicine (URM), to healthcare
34 careers.
- 35 8. Our AMA will create and support pipeline programs and encourage support services for URM
36 college students that will support them as they move through college, medical school and residency
37 programs.
- 38 9. Our AMA will recommend that medical school admissions committees and residency/fellowship
39 programs use holistic assessments of applicants that take into account the diversity of preparation
40 and the variety of talents that applicants bring to their education with the goal of improving health
41 care for all communities.
- 42 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of
43 demographic information pertaining to URM status collected from Electronic Residency
44 Application Service (ERAS) applications through the National Resident Matching Program
45 (NRMP).
- 46 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that
47 was initiated by the Commission to End Health Care Disparities.
- 48 12. Our AMA opposes legislation that would undermine institutions' ability to properly employ
49 affirmative action to promote a diverse student population.
- 50 13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC
51 electronic medical school application to identify previous pipeline program (also known as

1 pathway program) participation and create a plan to analyze the data in order to determine the
2 effectiveness of pipeline programs.

3
4 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection
5 Process D-310.945

6 Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship
7 programs to work toward ethical, equitable, and transparent recruiting processes, which are made
8 available to all applicants.

9 2. advocate for residency and fellowship programs to avoid using objective criteria available in the
10 Electronic Residency Application Service (ERAS) application process as the sole determinant for
11 deciding which applicants to offer interviews.

12 3. advocate to remove membership in medical honor societies as a mandated field of entry on the
13 Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated
14 screening mechanism—and encourage applicants to share this information within other aspects of
15 the ERAS application.

16 4. advocate for and support innovation in the undergraduate medical education to graduate medical
17 education transition, especially focusing on the efforts of the Accelerating Change in Medical
18 Education initiative, to include pilot efforts to optimize the residency/fellowship application and
19 matching process and encourage the study of the impact of using filters in the Electronic Residency
20 Application Service (ERAS) by program directors on the diversity of entrants into residency.

21 5. encourage caution among medical schools and residency/fellowship programs when utilizing
22 novel online assessments for sampling personal characteristics for the purpose of admissions or
23 selection and monitor use and validity of these tools.

24
25 Clinical Skills Assessment During Medical School D-295.988

26 1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education
27 (LCME) to ask the LCME to determine and disseminate to medical schools a description of what
28 constitutes appropriate compliance with the accreditation standard that schools should "develop a
29 system of assessment" to assure that students have acquired and can demonstrate core clinical
30 skills.

31 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical
32 Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the
33 transition from and replacement for the current United States Medical Licensing Examination
34 (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical
35 Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to
36 pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College
37 Accreditation-accredited medical school-administered, clinical skills examination.

38 3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current
39 examination process to reduce costs, including travel expenses, as well as time away from
40 educational pursuits, through immediate steps by the Federation of State Medical Boards and
41 National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the
42 number of available testing sites; (c) allow international students and graduates to take the same
43 examination at any available testing site; (d) engage in a transparent evaluation of basing this
44 examination within our nation's medical schools, rather than administered by an external
45 organization; and (e) include active participation by faculty leaders and assessment experts from
46 U.S. medical schools, as they work to develop new and improved methods of assessing medical
47 student competence for advancement into residency.

48 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical
49 education programs have demonstrated competence in clinical skills.

1 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for
2 assessing clinical skills are evidence-based and most efficiently use the time and financial
3 resources of those being assessed.

4 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-
5 takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of
6 suboptimal performance; and (c) give students who fail the exam insight into the areas of
7 unsatisfactory performance on the examination.

8 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data
9 and engage with stakeholders as necessary should updates to this policy become necessary.

10
11 Competency Based Medical Education Across the Continuum of Education and Practice D-
12 295.317

13 1. Our AMA Council on Medical Education will continue to study and identify challenges and
14 opportunities and critical stakeholders in achieving a competency-based curriculum across the
15 medical education continuum and other health professions that provides significant value to those
16 participating in these curricula and their patients.

17 2. Our AMA Council on Medical Education will work to establish a framework of consistent
18 vocabulary and definitions across the continuum of health sciences education that will facilitate
19 competency-based curriculum, andragogy and assessment implementation.

20 3. Our AMA will continue to explore, with the Accelerating Change in Medical Education
21 initiative and with other stakeholder organizations, the implications of shifting from time-based to
22 competency-based medical education on residents' compensation and lifetime earnings.

23
24 Competency-Based Portfolio Assessment of Medical Students D-295.318

25 1. Our AMA will work with the Association of American Medical Colleges, the American
26 Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other
27 organizations to examine new and emerging approaches to medical student evaluation, including
28 competency-based portfolio assessment.

29 2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating
30 Change in Medical Education consortium to develop pilot projects to study the impact of
31 competency-based frameworks on student graduation, the residency match process and off-cycle
32 entry into residency programs.

33
34 Continued Support for Diversity in Medical Education D-295.963

35 Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2)
36 request that the Liaison Committee on Medical Education regularly share statistics related to
37 compliance with accreditation standards IS-16 and MS-8 with medical schools and with other
38 stakeholder groups; (3) work with appropriate stakeholders to commission and enact the
39 recommendations of a forward-looking, cross-continuum, external study of 21st century medical
40 education focused on reimagining the future of health equity and racial justice in medical
41 education, improving the diversity of the health workforce, and ameliorating inequitable outcomes
42 among minoritized and marginalized patient populations; and (4) advocate for funding to support
43 the creation and sustainability of Historically Black College and University (HBCU), Hispanic-
44 Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and
45 residency programs, with the goal of achieving a physician workforce that is proportional to the
46 racial, ethnic, and gender composition of the United States population.

47
48 Decreasing Bias in Evaluations of Medical Student Performance D-295.307

49 Our AMA will work with appropriate stakeholders to promote efforts to evaluate methods for
50 decreasing the impact of bias in medical student performance evaluation as well as reducing the
51 impact of bias in the review of disciplinary actions.

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Fostering Professionalism During Medical School and Residency Training D-295.983

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.

(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.

(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.

(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.

(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.

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

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

- 1 Increasing Demographically Diverse Representation in Liaison Committee on Medical Education
- 2 Accredited Medical Schools D-295.322
- 3 Our AMA will continue to study medical school implementation of the Liaison Committee on
- 4 Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation
- 5 organizations and all state medical associations for action on demographic diversity.
- 6
- 7 Supporting Two-Interval Grading Systems for Medical Education H-295.866
- 8 Our AMA will work with stakeholders to encourage the establishment of a two-interval grading
- 9 system in medical colleges and universities in the United States for the non-clinical curriculum.
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- 11

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 05-A-23

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 Resolution 314-A-22, “Support for Institutional Policies for Personal Days for Undergraduate
2 Medical Students,” was authored by the American Medical Association (AMA) Medical Student
3 Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The
4 resolution reads as follows:

5
6 RESOLVED, That our American Medical Association encourage medical schools to accept
7 flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it
8 further

9
10 RESOLVED, That our AMA support a clearly defined number of easily accessible personal
11 days for medical students per academic year, which should be explained to students at the
12 beginning of each academic year and a subset of which should be granted without requiring an
13 explanation on the part of the students. (New HOD Policy)

14
15 The resolution was subsequently referred by the HOD for a report back to the House; this report is
16 in response to the referral.

17
18 BACKGROUND

19
20 *Concerns expressed by the resolution’s author*

21
22 The resolution stresses the frequency of burnout and its impact on the professional development
23 and mental health of medical students and identifies a lack of protected time as the prominent
24 barrier preventing medical students from accessing mental health treatment. The author expresses
25 concern regarding the inconsistency and lack of standardization of institutional policies for the
26 implementation of excused absences and the level of disclosure required by the students,
27 recognizing that students may not feel comfortable sharing mental health concerns due to
28 professional stigma, shame, or fear of repercussion.

29
30 *Reference Committee C testimony on the resolution*

31
32 The Reference Committee C report at the 2022 Annual Meeting reflected mixed testimony on this
33 item of business. Some testimony indicated support for this resolution, while others recommended
34 referral for further study due to concerns that using excessive personal days during a given
35 clerkship would have significant repercussions on the quality of education. While there was
36 support for the use of personal days by medical students, it was noted that determining a defined
37 number of personal days per academic year may be difficult given the variances across medical

1 schools. For these reasons, the resolution was recommended for referral by the reference
2 committee; the HOD subsequently concurred with this recommendation.

3
4 *Council on Medical Education testimony on the resolution*

5
6 In its testimony, the AMA Council on Medical Education stated that the AMA has a large amount
7 of policy on burnout in medical students, but nothing specific to personal days or less restrictive
8 excused absences. The Council recommended that the resolution be amended by adding the
9 language of the first resolve to current policy D-310.968 (3), “Physician and Medical Student
10 Burnout,” and adding a new resolve that the AMA support a clearly defined number of easily
11 accessible personal days for medical students per academic year, which should be explained to
12 students at the beginning of each academic year and a subset of which should be granted without
13 requiring an explanation on the part of the students. The Council recognized the possibility of
14 misuse of these days but noted that providing for but limiting the number of personal days provides
15 for both greater flexibility as well as privacy for students.

16
17 DISCUSSION

18
19 The goal of undergraduate medical education and awarding of the medical degree is to ensure that
20 medical students have acquired the knowledge, skills, and professional behaviors that prepare them
21 for a spectrum of career choices in medicine. Medical schools need to create an educational
22 environment that assures that graduating medical students meet the standards for achieving the
23 medical degree with the flexibility to meet the individual needs of their students.

24
25 *Time constraints as a barrier to medical student mental health care and well-being*

26
27 Burnout among medical students and the need for initiatives to counter burnout are well-
28 documented. Approximately half of U.S. medical students report experiencing burnout, and
29 medical students are more likely than their same-age peers outside of medicine to experience
30 depression or depressive symptoms (a prevalence of 27.2 percent)¹ and suicidal ideation (overall
31 prevalence of 11.1 percent).² Until recently, studies into obtaining timely mental health care
32 treatment and obstacles to care for students have been limited. However, one of the most frequently
33 cited barriers in this earlier research is lack of time.³

34
35 To gain a more thorough understanding, the University of Michigan conducted a study in 2020 of
36 current and recently graduated medical students, including pre-clinical, core clinical, and clinical
37 elective students. The goal of the study was to identify rates of burnout, barriers to treatment, and
38 program preferences for medical students.⁴ The results demonstrated the negative impact that lack
39 of time had on medical student access to mental health services as time constraints were the most
40 commonly reported barrier to accessing care. Of the participants who identified barriers to
41 obtaining care (77 of 312 respondents), 60 percent noted lack of time. In addition, 43 percent of
42 respondents felt that their schedule did not leave them with enough time for personal or family life,
43 another aspect of well-being impacted by time constraints. Students in the study were given the
44 option to provide suggestions for improvement, with flexibility in pre-clinical and core clerkship
45 schedules the most frequently mentioned theme.

46
47 *Concerns regarding stigma and potential career impact*

48
49 Stigma and fear of professional consequences also influence whether medical students seek mental
50 health treatment. In a 1994 study of first- and second-year medical students at the University of
51 California, San Francisco, School of Medicine, approximately one third of the students identified

1 as depressed cited the stigma associated with using mental health services and lack of
2 confidentiality as reasons for not seeking treatment.³ (The questionnaire was constructed to identify
3 the medical students' severity of depression by using the 13-item Beck Depression Inventory, a
4 standardized measure of depression symptoms.) In a 2009 cross-sectional student survey at a large
5 Midwestern medical school, most students cited potential embarrassment and the adverse effects
6 that disclosing mental illness could have on their professional development.⁵

7
8 The 2020 University of Michigan study also identified similar sentiments among its medical
9 students. The aspect of mental health services that students most endorsed was the guarantee that
10 seeking mental health care would have no negative impact on a student's future career (78 percent).
11 The study noted that policies concerning the reporting of mental health treatment to residency
12 programs and questions asked by licensing boards are variable and unclear, with many students
13 avoiding treatment for fear that future employers would view such treatment unfavorably.⁴

14 *Medical education accreditation standards related to student mental health*

15
16
17 The Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic
18 College Accreditation (COCA) have assessed the need for addressing medical student mental
19 health and have issued specific requirements on standards for accreditation to allopathic and
20 osteopathic medical schools, respectively.

21
22 LCME standards (Element 12.3 – Personal Counseling/Mental Health/Well-Being Programs,
23 Element 12.4 – Student Access to Health Care Services, and Element 12.5 Non-Involvement of
24 Providers of Student Health Services in Student Assessment/Location of Student Health Records)
25 require that health professionals providing any services, including psychiatric or psychological
26 counseling, should not be involved in the academic assessment or promotion of students in a
27 medical school program. Legal requirements for security, privacy, confidentiality, and accessibility
28 should be met when maintaining medical student health records. Furthermore, these standards state
29 that diagnostic, preventive, and therapeutic health services must be accessible to medical school
30 students near the site of their required educational experiences, which may include classroom
31 facilities, rotation sites, etc. Policies should be in place that allow students to be excused to seek
32 necessary health care.⁶

33
34 COCA standards (Element 5.3 – Safety, Health, and Wellness, Element 9.8 – Mental Health
35 Services, and Element 9.9 Physical Health Services) require that medical schools publish and
36 follow policies related to student, faculty, and staff mental health and wellness and fatigue
37 mitigation; provide students with confidential access to an effective system of counseling and
38 mental health care, with a mental health representative accessible 24 hours a day, 365 days a year,
39 from all locations where students receive education from the medical school; and provide students
40 with access to diagnostic, preventive, and therapeutic health services 24 hours a day, 365 days a
41 year, accessible in all locations where students receive education from the medical school.⁷

42 *Medical school attendance policies and impact of absences on education*

43
44
45 Medical school policies regarding excused absences and the use of personal days vary as schools
46 set policy to fit their specific curriculum structure. Therefore, standardization of these policies
47 would prove difficult.

48
49 In a sampling of medical school attendance policies regarding health-related excused absences,⁸⁻¹⁵
50 acceptable reasons included: illness affecting one's ability to report to the scheduled session and
51 necessary health care services which cannot be rescheduled, such as preventive health services,

1 care for chronic illnesses, physical therapy, and counseling/psychological services. In some
2 instances, students were not required to disclose the specific type of health care being sought.
3 Students were strongly encouraged to schedule non-emergency health care appointments during
4 times that do not conflict with classroom and clinical activities.

5
6 The number and timing of absences can impact the quality of the education, and there are many
7 issues to consider, including the potential for accumulation and use of absences over one or more
8 experiences; the active participation required by some curricular and clinical experiences over a
9 limited number of days; the impact on individual vs. team learning; and student responsibility for
10 the content or experiences missed. Medical schools should recognize that some students will be
11 absent during any curricular component and should develop alternative, timely means for students
12 to achieve curricular goals affected by an absence and avoid educational delays.

13
14 School policy varied regarding the number and timing of excused absences allowed, usually
15 limiting the number of absences per course, block, or year, and with restrictions on use, such as
16 during testing, orientation, or critical learning experiences.^{8,9,10,11} Some schools allowed these
17 excused absences to be applicable equally across all phases of training (foundational and clinical),
18 while for others absence from clinical duties was more restricted because it would decrease the
19 total amount of time in clinical service and thus impact a valid assessment of clerkship
20 performance.^{12,13}

21
22 In addition to excused absences, several of the schools in the sampling had personal day policies.
23 One school had core clerkship personal days, with a personal day defined as a day during a
24 required clerkship in the third year when a medical student would be excused from the rotation and
25 not required to state the reason. This policy allowed two personal days in the third year, and no
26 more than one personal day could be taken on any individual clerkship. Personal days were
27 restricted in some instances, such as exams, orientation, and assignments in which a student has
28 responsibilities that would impact the clerkship, i.e., overnight or weekend call.¹⁴ Another school
29 allowed students up to three personal day passes during the pre-clerkship phase to attend to
30 personal business. Personal day passes were restricted in some instances, such as exams and
31 interprofessional activities, and a specific reason for using a personal day pass was not required.¹⁵

32 33 RELEVANT AMA POLICY

34
35 The AMA has policy in support of identification and management of stress and burnout in students
36 and prioritizing self-care. The most specific policies related to the topic of this report are as
37 follows:

- 38
39
- 40 • D-345.983, “Study of Medical Student, Resident, and Physician Suicide,” which supports
41 the education of faculty members, residents, and medical students in the recognition of the
42 signs and symptoms of burnout and depression and access to free, confidential, and
43 immediately available stigma-free mental health and substance use disorder services.
 - 44 • D-405.978, “Access to Confidential Health Care Services for Physicians and Trainees,”
45 which includes advocating that medical students maintain self-care and are supported by
46 their institutions in their self-care efforts.
 - 47 • H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,”
48 which in part asks that accreditation bodies encourage medical schools to make available
49 confidential health care in reasonable proximity to the education/training site and consider
50

1 designating some segment of already-allocated personal time off specifically for routine
2 health screening and preventive services.

- 3
- 4 • H-405.960, “Policies for Parental, Family and Medical Necessity Leave,” which in part
5 encourages medical schools to develop written policies on parental leave, family leave, and
6 medical leave for medical students, including how time can be made up in order for
7 medical students to be eligible for graduation with minimal or no delays, and whether
8 schedule accommodations are allowed.

9
10 These policies are listed in full detail in Appendix A.

11
12 SUMMARY AND RECOMMENDATIONS

13
14 Resolution 314-A-22 requests that the AMA 1) encourage medical schools to accept flexible uses
15 for excused absences from clinical clerkships and 2) support a clearly defined number of easily
16 accessible personal days for medical students per academic year, some of which should be granted
17 without requiring an explanation on the part of the students.

18
19 Time constraints and the fear of stigma and negative professional consequences are key barriers to
20 medical student access to care. Existing AMA policy supports the identification and management
21 of medical student burnout and the prioritization of self-care by medical students and their
22 institutions, including the allocation of time and access to services. However, the impact of excused
23 absences on medical student education must be considered carefully, including their use, quantity,
24 and timing, as medical schools create and implement policy with their own curriculum structures in
25 mind.

26
27 The Council on Medical Education therefore recommends that the following recommendation be
28 adopted in lieu of Resolution 314-A-22 and the remainder of this report be filed:

- 29
- 30 1. That our AMA support a requirement that each medical school have policy defining 1) the
31 number of days a medical student may be excused from each curricular component; 2) the
32 processes for using excused absences, providing alternative, timely means of achieving
33 curricular goals when absent from a curricular component; and 3) effective mechanisms to
34 communicate these policies at appropriate times throughout the curriculum; and that
35 schools be encouraged to create a mechanism by which at least some portion of such days
36 can be used without requiring explanation. (New HOD Policy)

Fiscal note: TBD

APPENDIX: RELEVANT AMA POLICY

[D-345.983, “Study of Medical Student, Resident, and Physician Suicide”](#)

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

(CME Rep. 06, A-19; Modified: Res. 326, A-22)

[D-405.978, “Access to Confidential Health Care Services for Physicians and Trainees”](#)

1. Our AMA will advocate that: (a) physicians, medical students and all members of the health care team (i) maintain self-care, (ii) are supported by their institutions in their self-care efforts, and (iii) in order to maintain the confidentiality of care, have access to affordable health care, including mental and physical health care, outside of their place of work or education; and (b) employers support access to mental and physical health care including but not limited to providing access to out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment.
2. Our AMA will advocate for best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.

(Res. 7, I-20)

[H-295.858, “Access to Confidential Health Services for Medical Students and Physicians”](#)

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

- C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
 - D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
 3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
 - A. be available to all medical students on an opt-out basis;
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
 4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

(CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22)

[H-405.960, “Policies for Parental, Family and Medical Necessity Leave”](#)

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 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 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 will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, 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.
8. Residency programs should develop written policies on 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) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) 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; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. 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) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical student to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. 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.

11. 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.

12. 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.

13. 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.

14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.

15. 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.

16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.

17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

(CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 06-A-23

Subject: Modifying Financial Assistance Eligibility Criteria for Medical School Applicants

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

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At its 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy [D-305.950](#), “Modifying Financial Assistance Eligibility Criteria for Medical School Applicants,” which directs the AMA to:

work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other appropriate stakeholders to study process reforms that could help mitigate the high cost of applying to medical school for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria.

Testimony during the meeting expressed concern that applicants to medical school are often required to disclose their parental financial information, regardless of whether the applicant would individually meet a lower income threshold or are eligible for extensive financial aid through federal programs. This report will review the application process as well as the fee assistance programs and discuss reforms and resources to further aid individuals struggling to afford the high costs of application to medical school.

BACKGROUND

Journey into medical school and associated costs

The preparation to apply to medical school begins well before filling out an application form, starting with completion of high school education or General Education Development test (GED), as required for entry into an undergraduate degree program. According to the National Center for Education Statistics (NCES), 86 percent of students earned a diploma at the end of the 2018-2019 school year — an all-time high. Asian/Pacific Islander students had the highest adjusted cohort graduation rate (93 percent), followed by White (89 percent), Hispanic (82 percent), Black (80 percent), and American Indian/Alaska Native (74 percent) students.¹

The following table provides detail regarding the related steps for entry into medical school and their related costs (as of 2023):

Requirement	MD	DO	Associated costs
Undergraduate program (average 4 years)	Tuition, books, and related fees. Completion of bachelor's degree, inclusive of prerequisite courses. Some students may qualify for scholarships or waivers.		Expenses related to travel, housing, food, health care, electronic device, internet access.
Medical College Admissions Test® (MCAT®)	\$330 standard fee ² \$120 nonrefundable international fee (for examinees testing outside the U.S., Canada, or U.S. Territories; in addition to the standard fee). ² Students who qualify for the Association of American Medical Colleges' Fee Assistance Program (FAP) pay a reduced fee of \$135. ²		Expenses related to test preparation tools/courses; travel to test site, lodging, food.
Primary medical school application fee	American Medical College Application Service® (AMCAS®): \$170 for first school. ³ \$43 for each additional school.* Some schools do not use AMCAS.	American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) \$198 for first school. ⁴ \$50 for each additional school.	Expenses related to application preparation tools, electronic device, internet access, college service fees (e.g., transmit transcript and/or letters of recommendation.
Secondary application fee	Average \$50-100 per school*		Electronic device, internet access.
Access to database about medical schools	Optional subscription to Medical School Admission Requirements® (MSAR®) database to view information about allopathic medical schools. \$28 for one year, \$36 for two years, free to FAP students. ⁵	Optional free access to Choose DO Explorer to view information about osteopathic medical schools.	Electronic device, internet access.
Medical school interviews (virtual or in person)	Costs may vary depending on mode of travel, lodging, attire, meals per interview location.		Electronic device, internet access.

1 *2022 data indicates an average of 18 primary applications per applicant (990,790 applications were submitted by 55,188
2 applicants).⁶

1 Acceptance into medical school is an expensive and time-consuming endeavor. Many applicants
 2 are financially assisted by others (parents, guardians) to pursue this process; however, some
 3 students are not financially dependent on their parents — for a variety of reasons. Yet the
 4 applications often require the applicant to disclose parental financial information. Further, this
 5 requirement does not seem to consider whether the applicant would individually without parental
 6 income meet a lower income threshold or be eligible for financial aid.

7
 8 *Financial assistance for medical school applications fees*

9
 10 AMCAS® application to allopathic medical school

11
 12 The Association of American Medical Colleges (AAMC) offers the [American Medical College](#)
 13 [Application Service®](#) (AMCAS®), a centralized medical school application processing service used
 14 by most U.S. medical schools as the primary application method for their first-year entering
 15 classes. The subsection of the application called “Childhood Information” asks questions about the
 16 applicant’s “parents and guardians” as well as how the applicant paid for an undergraduate
 17 education. It asks about percent scholarship, percent parental contribution, and percent of
 18 contribution from self. The applicant is able to respond “don’t know” or “decline to answer” to the
 19 question about family income. According to the 2023 AMCAS® Applicant [Guide](#), it uses such
 20 terms as “immediate family,” “medically underserved,” “state or federal assistance programs,” and
 21 “Pell Grants.” See Appendix A for examples of relevant questions in the AMCAS application.

22
 23 The AAMC’s [Fee Assistance Program](#) (FAP) assists those who, without financial assistance, would
 24 otherwise be unable to take the Medical College Admission Test® (MCAT®), apply to medical
 25 schools that use the American Medical College Application Service® (AMCAS®), etc. This
 26 program requires the applicant, if under age 26, to provide their parents’ financial information and
 27 supporting tax documentation regardless of the applicant’s marital status, tax filing status
 28 (independent or dependent), parents’ country of residence, or whether their parents are willing to
 29 provide documentation. Exemptions from providing parental information include if the applicant:

- 30
- 31 • is legally emancipated,
 - 32 • does not know if a parent is living,
 - 33 • does not have a relationship with a parent and does not communicate with them,
 - 34 • was in foster care or in the care of a legal guardian at the time they reached the age of
 majority,
 - 35 • another circumstance that prohibits the obtaining of parent’s financial information.⁷

36 In addition, exemption will be made if the parent is deceased, incarcerated, institutionalized, or
 37 permanently incapacitated or hospitalized.

38
 39 AACOMAS application to osteopathic medical school

40
 41 Similar to AMCAS, the American Association of Colleges of Osteopathic Medicine (AACOM)
 42 offers their own [Application Service](#) (AACOMAS). This application has a section entitled “Family
 43 Information” which requires the applicant to provide parents’ names, note if parents are living or
 44 deceased, and provide any relatives who are DOs or MDs. It also asks optional questions about
 45 parents’ occupation, residency, education, and household. A section called “Other information”
 46 collects “background information” that includes questions related to family income. Explanations
 47 are provided in the Applicant [Help Center](#). See Appendix B for examples of relevant questions in
 48 the AACOMAS application.

1 AACOM offers the [Fee Waiver Program](#). Students must apply to this program and receive
2 approval, if applicable, before submitting their AACOMAS application. Applicant Help Center
3 provides additional information on eligibility. Applicants who are not listed as a “dependent” on a
4 previously filed Federal Income Tax Return Form 1040 are classified as “independent applicants.”
5 AACOM requires the applicant to submit both their own and their parent or guardian’s 1040 forms.

6 7 *Federal financial assistance requirements*

8 9 Definition of “low-income”

10
11 The U.S. Department of Health and Human Services (HHS) defines “low-income levels” used for
12 various health professions as authorized in Titles III, VII, and VIII of the Public Health Service
13 Act. This information is periodically published in the Federal Register. Effective January 12, 2022,
14 a “low-income family/household” is defined as having an annual income that does not exceed 200
15 percent of HHS’s poverty guidelines.⁸ “A family is a group of two or more individuals related by
16 birth, marriage, or adoption who live together. Most HRSA programs use the income of a student’s
17 parent(s) to compute low-income status. However, a ‘household’ may potentially be only one
18 person.”⁸ Low-income levels are adjusted annually based on poverty thresholds published by the
19 U.S. Census Bureau.

20 21 Free Application for Federal Student Aid

22
23 The [Free Application for Federal Student Aid](#) (FASFA[®]), offered by the U.S. Department of
24 Education, is a mechanism for students to apply for federal grants, work-study, and loans before
25 each year of college. Such institutions use FAFSA data to determine an applicant’s federal aid
26 eligibility. The FASFA form makes clear that the student is the one applying for financial aid.
27 Dependent students and their parents/guardians must both create FASFA IDs online and provide
28 parental information in the application. If a parent does not have a Social Security number (SSN),
29 they will not be able to create an FASFA ID (which requires an SSN). Unfortunately, this presents
30 challenges for many parents who are not U.S. citizens. The FASFA program currently defines an
31 “independent student” as one of the following:

- 32 • born before Jan. 1, 1999
- 33 • married
- 34 • a graduate or professional student
- 35 • a veteran
- 36 • a member of the armed forces
- 37 • an orphan
- 38 • a ward of the court
- 39 • someone with legal dependents other than a spouse
- 40 • an emancipated minor
- 41 • someone who is homeless or at risk of becoming homeless.⁹

42 43 DISCUSSION

44 45 *Recent changes*

46
47 Changes to application forms as well as the programs that create and maintain the forms are likely
48 to impact the students who apply, or wish to apply, to medical school. Recent examples of changes
49 are explained below.

1 FAP reforms

2
3 In 2022, the AAMC introduced the following changes to the FAP:

- 4 • Free and discounted items related to the MCAT and MSAR as noted in the table above.
5 • Open to everyone with a permanent U.S. address. Reference to U.S. citizenship and certain
6 visa status eligibility requirements have been removed.
7 • Parental financial information is NOT required for applicants over age 26 on the day the
8 application is submitted. Eligibility depends on income and poverty guidelines.
9 • Benefits are not retroactive. If awarded fee assistance, the applicant cannot apply benefits
10 to previous registrations or purchases.
11 • Fee for secondary applications may be waived at some medical schools.¹⁰

12
13 Of note, many medical students apply and enter when they are younger than 26 (likely ages 22-24).
14 Therefore, this benefit may not help most applicants.

15
16 Blockage of the Biden Administration debt relief program

17
18 Due to the economic challenges created by the COVID-19 pandemic, the Biden-Harris
19 Administration issued a debt relief program to

- 20 • extend the pause on student loan repayments a few times, whereby no one with a federally
21 held loan has had make a loan payments since President Biden took office,
22 • “provide up to \$20,000 in debt relief to Pell Grant recipients with loans held by the
23 Department of Education (DOE) and up to \$10,000 in debt relief to non-Pell Grant
24 recipients. Borrowers are eligible for this relief if their individual income is less than
25 \$125,000 or \$250,000 for households. In addition, borrowers who are employed by non-
26 profits, the military, or federal, state, Tribal, or local government may be eligible to have
27 all of their student loans forgiven through the Public Service Loan Forgiveness (PSLF)
28 program,”
29 • propose a rule change to create a new income-driven repayment plan to reduce future
30 monthly payments for lower- and middle-income applicants.¹¹

31
32 However, courts have issued orders blocking this student debt relief program and, as a result,
33 applications are not being accepted at this time. This halt to the application process is likely having
34 a real impact on medical school applicants. The Administration is seeking to overturn those orders.
35 Thus, the student loan payment pause is extended until the DOE is permitted to implement the
36 program or the litigation is resolved; if not resolved by June 30, 2023, then payments will resume
37 60 days after that.¹¹

38
39 RELEVANT AMA POLICIES

40
41 The AMA has several related policies in place addressing medical school cost, debt, and diversity;
42 however, none specifically address the cost and aspects of the application form itself. Related
43 policies are listed here, and full text is available in Appendix C.

- 44 • [H-295.888, Progress in Medical Education: the Medical School Admission Process](#)
45 • [D-200.985, Strategies for Enhancing Diversity in the Physician Workforce](#)
46 • [H-305.925, Principles of and Actions to Address Medical Education Costs and Student](#)
47 [Debt](#)
48 • [H-305.988, Cost and Financing of Medical Education and Availability of First Year](#)
49 [Residency Positions](#)

- 1 • [H-350.979, Increase the Representation of Minority and Economically Disadvantaged](#)
- 2 [Populations in the Medical Profession](#)
- 3 • [D-295.303, Support Hybrid Interview Techniques for Entry to Graduate Medical](#)
- 4 [Education](#)
- 5 • [H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in](#)
- 6 [US Medical Schools](#)
- 7

8 SUMMARY AND RECOMMENDATIONS

9
10 The entire process surrounding acceptance into medical school is costly and time-consuming. The
11 application itself is a significant expense and may require the student to disclose information about
12 their parents and related income, even if the student is not being financially supported by them.
13 Some families may financially support students but struggle to do so. Given limited resources,
14 financial programs should prioritize low-income families and/or independent students. Further
15 study is needed in order to propose equitable process reforms that could help mitigate the high cost
16 of applying to medical school, particularly for low-income students.

17
18 The Council on Medical Education therefore recommends that the following recommendations be
19 adopted, and the remainder of this report be filed:

- 20
21 1. That AMA policy [D-305.950](#), Modifying Financial Assistance Eligibility Criteria for
22 Medical School Applicants, be amended by addition and deletion to read as follows:

23
24 1. Our AMA will ~~work with~~ encourage the Association of American Medical Colleges, and
25 American Association of Colleges of Osteopathic Medicine, and other appropriate
26 stakeholders to study process reforms that could help to mitigate the high cost of applying
27 to medical school for low-income applicants, including better targeting application fee
28 waivers through broadened eligibility criteria, and ensure cost parity among applicants to
29 DO and MD granting institutions.

30
31 2. Our AMA will encourage the Association of American Medical Colleges, American
32 Association of Colleges of Osteopathic Medicine, and U.S. Department of Education to
33 reevaluate application forms to financial aid programs such as the Fee Assistance Program
34 (FAP), Fee Waiver Program (FWP), and Free Application for Federal Aid (FASFA) to
35 broaden eligibility criteria for low-income students.

36
37 3. Our AMA will commend the U.S. Department of Education for removing references to
38 parental/guardian income for all medical students in the Free Application for Federal Aid
39 (FASFA).

40
41 4. Our AMA will encourage the Association of American Medical Colleges and American
42 Association of Colleges of Osteopathic Medicine as well as medical school and state-based
43 financial aid programs to remove references to parental/guardian income for all medical
44 students and follow the U.S. Department of Education's definition of "independent
45 student" as described in the Free Application for Federal Aid (FASFA). (Modify Current
46 HOD Policy)

Fiscal note: \$1,000.

APPENDIX A

Relevant AMCAS application questions

Childhood Information

In what area did you spend the majority of your life from birth to age eighteen?

Country *

⚠ Please select the country.

City *

⚠ Please enter the city.

Description *

⚠ Please select the description.

Do you believe that this area was medically under-served? *

- Yes
- No
- Don't know
- Decline to Answer

Have you or members of your immediate family ever used federal or state assistance programs? *

- Yes
- No
- Don't know
- Decline to Answer

What was the income level of your family during the majority of your life from birth to age eighteen? *

Did you have paid employment prior to age eighteen? *

- Yes
- No
- Decline to Answer

Were you required to contribute to the overall family income (as opposed to working primarily for your own discretionary spending money)? *

- Yes
- No
- Decline to Answer

How many people lived in your primary household during the majority of your life from birth to age eighteen? *

Did you receive a Pell Grant at any time while you were an undergraduate student? *

- Yes
- No
- Don't know
- Decline to Answer

How have you paid or did you pay for your post-secondary education? For each of the applicable options below, indicate the average percentage contribution towards your post-secondary education. The percentages entered should equal 100%:

Academic Scholarship %

Financial Need-Based Scholarship %

Student Loan %

Other Loan %

Family Contribution %

Applicant Contribution %

Other %

Total %

Parents and Guardians

Please add all of your parents and/or guardians. *

[ADD PARENT/GUARDIAN](#)

[I AM NOT ABLE TO PROVIDE THIS INFORMATION](#)

Siblings

Please add any siblings you have. Some medical schools want to know information about your brothers or sisters, if you have any. *

[ADD SIBLING](#)

[NONE](#)

Dependents

How many dependents do you have? *

APPENDIX B

Relevant AACOMAS application questions

Background Information

Check if any of the following apply to you:

- I graduated from a high school from which a low percentage of seniors receive a high school diploma.
- I graduated from a high school at which many of the enrolled students are eligible for free or reduced-price lunches.
- I am from a family that receives public assistance (e.g. Aid to Families with Dependent Children, food stamps, Medicaid, public housing) or I receive public assistance.
- I am from a family that lives in an area that is designated as a Health Professional Shortage Area or a Medically Underserved Area.
- I participated in an academic enrichment program funded in whole or in part by the Health Careers Opportunity Program.
- I am a high-school drop-out who received AHS diploma or GED.
- I am from a school district where 50% or less of graduates go to college or where college education is not encouraged.
- I am the first generation in my family to attend college (neither my mother nor my father attended college).
- English is not my primary language.

By designating any of the above, you are considered to have met the criteria for educationally/environmentally disadvantaged as defined by the above guidelines.

To determine if you come from an economically disadvantaged background, you are asked to compare your parental family's size of household (number of exemptions listed on parent's Federal 1040 income tax forms) and adjusted gross income against the chart provided in the link below. The chart is based on 200 percent of [Federal low-income poverty guidelines](#). You should use your parent's most recent tax forms regardless of age.

Your parent's family income falls within the table's guidelines and you are considered to have met the criteria for economically disadvantaged.

Yes No

* What is the type of geographic area where you were raised?

Pell Grant Information

Did you receive a Pell Grant at any time while you were an undergraduate student?

Yes No

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APPENDIX C

Relevant policies

H-295.888, Progress in Medical Education: the Medical School Admission Process

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

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

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

H-305.925, Principles of and Actions to Address Medical Education Costs and Student Debt

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit

100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

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

Our AMA:

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

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

- Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
- (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
 - (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
 - (4) Increasing the supply of minority health professionals.

- (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
- (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
- (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
- (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

D-295.303, Support Hybrid Interview Techniques for Entry to Graduate Medical Education

Our AMA will:

1. work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents.
2. encourage appropriate stakeholders, such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth, and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews.

H-255.968, Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools

Our AMA:

1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

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REPORT 07 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
Management and Leadership Training in Medical Education
(Reference Committee C)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy directing the AMA to “4.(a) study the extent of the impact of AMA Policy [D-295.316](#), ‘Management and Leadership for Physicians,’ on elective curriculum; and (b) expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.”

This report is written in response to these directives. While there is no clear way to study the extent of the impact of AMA policy on elective curricula, this report provides background on Policy D-295.316, describes efforts made to advance learning opportunities regarding physician management and leadership, and discusses how this topic relates to the foundational platform of health systems science.

Policy D-295.316 was originally adopted at the 2014 Interim Meeting. Since that time, it was amended at I-16 and A-18, reaffirmed at A-17, and amended at A-22 with the addition of a fourth clause, as noted above, which is the impetus for this report. Appendix A cites the various actions taken to accomplish this policy over the years. It also provides a listing of all the AMA programs, courses, and initiatives that address physician leadership and management. Further, this report describes the educational standards, competencies, and organizations that foster such knowledge and skills and analyzes data from the Liaison Committee on Medical Education and National GME Census related to leadership and health systems science.

This report recommends that policy D-295.316 be amended to clarify the ongoing efforts of the AMA, rescind clauses accomplished by this report, and add new directives related to data collection and analysis as well as the creation of an online directory of AMA resources.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 07-A-23

Subject: Management and Leadership Training in Medical Education

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates
2 (HOD) adopted new policy directing the AMA to:

3
4 (a) study the extent of the impact of AMA Policy [D-295.316](#), “Management and Leadership
5 for Physicians,” on elective curriculum; and (b) expand efforts to promote the tenets of health
6 systems science to prepare trainees for leadership roles and address prevalent challenges in the
7 practice of medicine and public health.

8
9 Testimony on this item supported the need for physician leaders and the development of necessary
10 leadership and communication skills. This is in alignment with the AMA’s work to inculcate health
11 systems science throughout the medical education curriculum as part of its Accelerating Change in
12 Medical Education initiative (now renamed ChangeMedEd).

13
14 This report is written in response to these newly adopted directives. While there is no clear way to
15 study the extent of the impact of AMA policy on elective curricula, this report provides
16 background on Policy D-295.316, describes efforts made to advance learning opportunities
17 regarding physician management and leadership, and discusses how this topic relates to the
18 foundational platform of health systems science.

19 20 BACKGROUND

21
22 *AMA Policy D-296.316, Management and Leadership for Physicians”*

23
24 Policy [D-295.316](#) was originally adopted at the 2014 Interim Meeting (I-14). It was amended at I-
25 16 and A-18 and most recently at A-22 with the addition of a fourth clause, which is the impetus
26 for this report. The policy was also reaffirmed at A-17. Currently, the full policy contains four
27 clauses and reads as follows:

- 28
29 1. Our AMA will study advantages and disadvantages of various educational options on
30 management and leadership for physicians with a report back to the House of Delegates; and
31 develop an online report and guide aimed at physicians interested in management and
32 leadership that would include the advantages and disadvantages of various educational options.
33 2. Our AMA will work with key stakeholders to advocate for collaborative programs among
34 medical schools, residency programs, and related schools of business and management to better

- 1 prepare physicians for administrative, financial and leadership responsibilities in medical
2 management.
- 3 3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula
4 that emphasize experiential and active learning models to include knowledge, skills and
5 management techniques integral to achieving personal and professional financial literacy and
6 leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical
7 Education initiative; and (b) will advocate with the Liaison Committee on Medical Education,
8 Association of American Medical Colleges and other governing bodies responsible for the
9 education of future physicians to implement programs early in medical training to promote the
10 development of leadership and personal and professional financial literacy capabilities.
- 11 4. Our AMA will: (a) study the extent of the impact of AMA Policy D-295.316, "Management
12 and Leadership for Physicians," on elective curriculum; and (b) expand efforts to promote the
13 tenets of health systems science to prepare trainees for leadership roles and address prevalent
14 challenges in the practice of medicine and public health.

15
16 From 2014-2016, AMA conducted a qualitative study and environmental scan to evaluate the
17 market for physician leadership training and development and to test the potential demand for
18 AMA-led programs. As a result of this research, the AMA launched the development of leadership-
19 related content for physicians specific to topics where the AMA has unique expertise at both the
20 individual and practice levels. Given the evolution of this policy from 2014 to 2022, several actions
21 were taken over the years to accomplish the directives in clauses (1)-(3). These actions are
22 enumerated in Appendix A and further addressed in the report's recommendations.

23 24 *Educational Standards, Competencies, and Resources*

25
26 Many organizations and institutions are responsible for the education of future physicians. They
27 may implement programs in medical training to promote the development of leadership as well as
28 personal and professional financial literacy capabilities. The Liaison Committee on Medical
29 Education (LCME) and Association of American Medical Colleges (AAMC), while not "governing
30 bodies" as stated in clause 3b of AMA policy D-295.316, do play a role. Likewise, the American
31 Osteopathic Association (AOA), Commission on Osteopathic College Accreditation (COCA),
32 American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council
33 for Graduate Medical Education (ACGME) also play important roles.

34
35 The LCME determines the [standards](#) an allopathic medical school must meet to maintain
36 accreditation. Such standards include Self-Directed and Life-Long Learning (6.3), Interprofessional
37 Collaborative Skills (7.9), and Financial Aid/Debt Management Counseling/Student Educational
38 Debt (12.1) — all of which address and support the topics raised in Policy D-295.316 clause (3a).¹
39 Similarly, COCA's [standards](#) include Curriculum Design and Management (6.1), Self-Directed
40 Learning (6.7), Interprofessional Education for Collaborative Practice (6.8), Financial Aid and
41 Debt Management Counseling (9.7), Student Debt Outcomes (11.3), and Title IV Responsibility
42 (12.9).²

43
44 The AAMC offers 15 competencies for entering medical students that lend themselves toward the
45 development of skills necessary for effective leadership.³ The AAMC's Group on Student Affairs
46 (GSA) supports professional development, inclusive of leadership skills, and offers a framework to
47 provide performance benchmarks.⁴ Further, the GSA provides various [resources](#) and a
48 downloadable, interactive [catalog](#) to identify which resources best suit the individual. For example,
49 the [Leadership Education and Development \(LEAD\) Certificate Program](#) is designed to foster
50 leaders in academic medicine.

1 The AACOM's [Leadership Institute](#) supports leadership development through a variety of
2 resources suitable for DOs at all career stages and pursuits, including a Senior Leadership
3 Development Program as well as a fellowship and internship in osteopathic health policy.
4

5 The ACGME Common Program Requirements, effective July 2022, establish that the
6 qualifications of a program director include leadership skills (II.A.3.a) and professionalism
7 (II.A.4.a).⁵ Likewise, a program coordinator should possess skills in management and leadership.
8 The requirements acknowledge that programs may place different emphasis on some skills such as
9 leadership. The "core competencies" of the ACGME and American Board of Medical Specialties
10 (ABMS) provide the foundation for residency milestones as well as board certification standards
11 ([initial](#) and [continuing](#)).⁶ These competencies address aspects of leadership:

- 12 • Patient Care and Procedural Skills
- 13 • Medical Knowledge
- 14 • Practice-based Learning and Improvement
- 15 • Interpersonal and Communication Skills
- 16 • Professionalism
- 17 • Systems-based Practice

18 19 DISCUSSION

20
21 Management and leadership skills are complementary and may overlap but their ultimate functions
22 differ. The concept of "leadership" seeks to move an organization toward achieving a strategic
23 vision through change. "Management" is a newer concept focused on organizational efficiency and
24 effectiveness while also addressing its complexity. In short, "leadership can be said to craft the
25 vision and strategy, and management is necessary to operationalize."⁷ Management training usually
26 includes topics such as business/practice management, organizational skills, time, and stress
27 management; whereas leadership training often addresses such topics as communication,
28 interpersonal skills, cultural sensitivity, facilitation, problem solving, team building, and conflict
29 resolution. It is important for good leaders to understand management principles to achieve their
30 vision. Leadership will be further explored in Council on Medical Education Report 9-A-23
31 addressing accreditation standards for competency in leading interprofessional health care teams.
32

33 *AMA Management and Leadership Opportunities*

34
35 The AMA's focused work in [Medical Education](#) as well as [Physician Satisfaction and Practice](#)
36 [Sustainability](#) offers a wide range of learning opportunities and resources that address the broad
37 and diverse topic of physician leadership.

- 38 • The AMA [Undergraduate Medical Education Curricular Enrichment Program](#) (UCEP), a
39 series of online educational modules designed to complement undergraduate medical
40 school curricula including modules on leadership.
- 41 • The AMA [Medical Student Leadership Learning Series](#) offers interactive modules that
42 provide realistic scenarios and resources to help medical students become skilled in core
43 competencies of leadership.
- 44 • The [Succeeding in Medical School](#) series provides medical students and international
45 medical graduates with medical school tips and other guidance on a wide range of critical
46 topics, including preparing for the United States Medical Licensing Examination[®]
47 (USMLE[®]), navigating clinical rotations, publishing scientific research, and maintaining
48 optimal health and wellness. It also provides opportunities for physicians to develop
49 leadership skills and advocate for patients and the profession.

- 1 • The AMA’s [Accelerating Change in Medical Education](#) initiative, recently renamed
2 ChangeMedEd, works across the education continuum with visionary partners to create
3 bold innovations in undergraduate and graduate medical education. It offers transformative
4 resources for learners and educators, as well as national events that disseminate
5 innovations to better train physicians to meet the needs of patients today and in the future.
6 Members of the Accelerating Change in Medical Education Consortium actively
7 collaborate on the development of leadership curricula at the undergraduate medical
8 education level. This includes resources to address [shaping tomorrow’s leaders](#). This
9 initiative also created the Health Systems Science framework, described in more detail
10 below.
- 11 • The AMA [GME Competency Education Program](#) (GCEP) offers a robust series of online
12 educational courses that complement teachings in residency and fellowship programs with
13 meaningful, nonclinical knowledge that is easy to digest, understand, and apply. Built for
14 busy residents, fellows, and faculty, GCEP offers flexible, self-paced learning with
15 convenient anytime, anywhere access. It covers pertinent topics in GME such as resident
16 well-being, sleep deprivation, the basics of health equity, and more. This award-winning
17 program can help residents and fellows meet core program requirements and prepare for
18 practice.
- 19 • The [Reimagining Residency](#) initiative is developing leadership training for residents.
20 Efforts include curricula in professional identity formation.
- 21 • The Resident Diversity Leadership Program, supported by the AMA and administered
22 through the University of Cincinnati, is a yearlong program for a cohort of 40 residents
23 from backgrounds that have been historically excluded from medicine that meets monthly
24 and works through a leadership curriculum.
- 25 • The [STEPS Forward](#)[®] practice innovation strategies offer real-world solutions to the
26 challenges that physicians face every day. It provides tools to address barriers and restore
27 joy in the practice of medicine. Further, STEPS Forward[®] offers proven approaches on
28 how to successfully lead and manage change initiatives, empower the team, and drive
29 tangible results. It offers a [toolkit](#) of resources and information on leadership in practice
30 and a pertinent webinar entitled “[Leading Through a Crisis: Communication During
31 COVID-19 Times](#).” STEPS Forward also features a module, entitled “Cultivating
32 Leadership: Measure and Assess Leader Behaviors to Improve Professional Well-Being,”
33 that guides learners in the importance of leadership in promoting well-being and
34 emphasizes ways to improve leadership in practice. Further, the [Joy in Medicine Health
35 System Recognition](#) program honors organizations that have demonstrated organizational
36 investment in promoting leadership development.
- 37 • The [AMA Ed Hub](#)[™] online learning platform provides high-quality education for
38 physicians and other medical professionals to stay current and continuously improve the
39 care they provide. It brings together education from trusted sources including the JAMA
40 Network[™] and the AMA Journal of Ethics[®] as well as curated content from external
41 providers including access to the [Stanford Leadership Virtual Journal Club](#). This platform
42 offers many educational opportunities (e.g., articles, podcasts, learning activities) that
43 address leadership, many of which offer CME credit.
- 44 • The [AMA Foundation](#)’s Leadership Development Institute offers a unique opportunity for
45 physicians to gain individualized insight into the skills needed to foster their careers and
46 the future of medicine. Participants receive professional development opportunities as well
47 as mentoring throughout the course of the program. Activities include a weekend retreat,
48 monthly training webinars, a year-long formal mentorship program and culminating
49 workshops held in conjunction with the AMA Annual Meeting.

- 1 • The [AMA Political Action Committee](#) (AMPAC) is a bipartisan committee whose mission
2 is to support candidates who will help medicine in Congress. In addition, AMPAC offers
3 two political education training programs to encourage and support more members of the
4 medical community to either seek public office or get involved in others' political
5 campaigns. AMPAC has proudly offered these programs for over 30 years and has trained
6 thousands of physicians to be successful candidates and activists.
- 7 • The AMA's Councils recommend educational policies to the AMA House of Delegates
8 and have written many reports that discuss leadership in varying capacities. For example,
9 the [Council on Medical Education](#) offered a report on the "[The Structure and Function of](#)
10 [Interprofessional Health Care Teams](#)" that addresses the role of the physician leader.
- 11 • Participation in the AMA [HOD](#), whether as a delegate/alternate delegate, ambassador,
12 and/or member of a section, council, or board, demonstrates proactive physician
13 leadership.

14
15 This rich variety of resources is available to students, trainees, physicians, and the medical
16 education community; members and institutions are encouraged to avail themselves of these
17 leadership training programs.

18 19 Health Systems Science

20
21 [Health systems science](#) (HSS) is a foundational platform and framework for understanding how
22 health care is delivered, how health care professionals work together to deliver that care, and how
23 the health system can improve patient care.

24
25 At the formation of the Accelerating Change in Medical Education initiative, the AMA called for
26 innovations in "Promoting exemplary methods to achieve patient safety, performance improvement
27 and patient-centered team-based care; and improving medical students' understanding of the health
28 care system and health care financing."⁸ Member medical schools of the Accelerating Change in
29 Medical Education Consortium collaborated to create and develop a replete framework for HSS.
30 The framework rests upon systems thinking to unify domains such as leadership, teaming, change
31 agency, health care structure and processes, policies and economics, value, improvement, and
32 more.

33
34 The consortium has developed multiple resources to support faculty development and the
35 integration of training in HSS into UME and then GME. Resources include a textbook (now in its
36 second edition), online modules hosted on the AMA Ed Hub™, a faculty scholars program, and an
37 implementation guidebook. A full inventory of resources is displayed on a public [landing page](#).
38 The AMA also hosted a Health Systems Science Summit in 2022 to promote dissemination in
39 UME and GME with over 250 participants.

40
41 A 2018 inventory of MD-granting medical schools conducted by the AMA demonstrated that most
42 schools have incorporated some elements of HSS, and over 50 percent use the AMA textbook as a
43 faculty resource. AMA staff and external partners continue to promote dissemination across UME
44 and GME.

45
46 *Data on related curricula and training*

47
48 [LCME Part II Annual Medical School Questionnaire](#)

1 This LCME questionnaire collects data on both leadership and health systems science within the
 2 medical school curriculum. The following data are from the 2021-2022 questionnaire with
 3 responses from all 155 LCME-accredited medical education programs.⁹
 4

	<i># of schools where topics are included</i>	
Topic	Required course in the pre-clerkship phase (Years 1 &2)	Required clerkship/ clinical discipline
Leadership	103	93
Health systems science	135	120

5
 6 National GME Census
 7

8 Starting in 2019, the program survey of the National GME Census, which provides information for
 9 FREIDA™, the AMA’s Residency and Fellowship Database®, asked if programs provided
 10 “Curriculum to develop health systems leadership skills (e.g., QI project leadership,
 11 community/organizational advocacy).”
 12

Type of program	<i>Number and percent of programs with leadership development curriculum*</i>							
	2019-2020	%	2020-2021	%	2021-2022	%	2022-2023	%
Residency	1421	27.2	1550	29.0	1547	28.4	1542	28.0
Fellowship	1181	16.9	1206	16.9	1135	15.4	1260	17.0
Program setting								
University hospital	1530	20.6	1593	21.3	1555	20.5	1535	20.4
Community hospital/ university affiliated	796	23.9	861	24.7	799	22.0	841	22.7
Community hospital	262	21.3	282	21.8	312	23.4	294	22.2
Other setting	14	6.0	20	8.6	16	6.8	132	35.5

13 Analysis of the American Medical Association’s GME Database.
 14 *Programs responding affirmatively to the question “Does the program offer... curriculum to develop health systems
 15 leadership skills (e.g., QI project leadership, community/organizational advocacy” in the National GME Census.
 16

17 There does not appear to be significant growth in the number of programs providing leadership
 18 training over the past four years. Residency programs appear more likely to report having the
 19 curriculum compared to fellowship programs. Community-based programs are slightly more likely
 20 to report having a curriculum compared to university-based programs.
 21

22 *Medical subspecialty proposal*

1 The certifying boards of multiple specialties, including the [American Board of Emergency](#)
2 [Medicine](#) (ABEM), [American Board of Anesthesiology](#), [American Board of Preventive Medicine](#),
3 and [American Board of Family Medicine](#), recently received approval from the ABMS Committee
4 on Certification (COCERT) for a subspecialty certification in Health Care Administration,
5 Leadership and Management (HALM). The ABEM application indicated the purpose of the
6 proposed certification is “to recognize expertise held by physicians with sophisticated,
7 comprehensive knowledge that covers the broad, system-based leadership needs of health care
8 environments, including those related to patient care as well as other health system administrative
9 and management needs. HALM integrates expertise from medicine, health systems science, quality
10 improvement, patient safety, business, public health, communication, computer science,
11 economics, law, and other disciplines in a singular subspecialty certification.”¹⁰ The ACGME has
12 approved program requirements for GME training programs in HALM, which can have accredited
13 lengths of either 12 or 24 months. While there are not yet any accredited programs, there are
14 similar programs already in existence that are likely to seek accreditation.

15 16 RELEVANT AMA POLICIES

17
18 In addition to Policy D-295.316, the AMA has other policies related to physician leadership and
19 management as listed here. These full policies are provided in Appendix B.

- 20 • [H-235.981](#), Qualifications, Selection, and Role of Medical Directors, Chief Medical
21 Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract
22 with Hospitals/Health Systems to Provide Medical Management Services
- 23 • [H-405.990](#), Physician Managers
- 24 • [H-445.984](#), Training Physicians and Physicians-in-Training in the Art of Public Speaking

25 26 SUMMARY AND RECOMMENDATIONS

27
28 The AMA has made significant efforts in the last 10-plus years to address, support, and advocate
29 for physician leadership. These efforts align with the educational standards regarding leadership set
30 by the accrediting bodies and are complemented by the many partnerships that have been forged to
31 advance physician leadership. It is very difficult to study the “extent of the impact” (as stated in the
32 new fourth clause of D-295.316) of a policy on elective curriculum with any degree of accuracy or
33 thoroughness given the wide scope of the resources offered, as described above. The research
34 conducted for this report indicates that the efforts made by the AMA, its partners, and other
35 external stakeholders continue to advance physician leadership by way of curricula, training
36 programs, resources, and development of a possible subspecialty. The AMA has made great strides
37 to embed leadership into the tenets of HSS to prepare trainees for leadership roles and address
38 prevalent challenges in the practice of medicine and public health. The AMA is committed to
39 continuing such efforts and promoting them accordingly.

40
41 The Council on Medical Education therefore recommends that the following recommendations be
42 adopted, and the remainder of this report be filed:

- 43
44 1. That clause (1) of AMA policy [D-295.316](#) be rescinded as such directives have been
45 accomplished per the actions, programs, and resources summarized in this report.

46
47 ~~1. “Our AMA will study advantages and disadvantages of various educational options~~
48 ~~on management and leadership for physicians with a report back to the House of~~
49 ~~Delegates; and develop an online report and guide aimed at physicians interested in~~
50 ~~management and leadership that would include the advantages and disadvantages of~~
51 ~~various educational options.” (Rescind HOD Policy)~~

1 2. That clauses (2) and (3) of AMA policy D-295.316 be amended by addition and deletion to
2 read as follows:
3

4 2. “Our AMA ~~supports will work with key stakeholders to advocate for~~ collaborative
5 programs among medical schools, residency programs, and related schools of business
6 and management to ~~better give physicians the opportunity to assume for~~
7 administrative, financial, and leadership responsibilities in medical management.”
8

9 3. “Our AMA: (a) ~~will advocate for and~~ supports and participates in the creation and
10 promotion of management and leadership programs and curricula that emphasize
11 experiential and active learning models to include knowledge, skills, and management
12 techniques integral to achieving ~~personal and professional~~ financial literacy and
13 leading interprofessional ~~team~~ health care teams, ~~in the spirit of the AMA’s~~
14 ~~Accelerating Change in Medical Education initiative~~; and (b) encourages will advocate
15 ~~with the Liaison Committee for Medical Education, Association of American Medical~~
16 ~~Colleges and other to~~ the organizations ~~governing bodies~~ responsible for the education
17 of future physicians to implement programs ~~early in~~ throughout medical training to
18 ~~promote the development of management and leadership competencies and personal~~
19 ~~and professional~~ financial literacy capabilities.” (Modify Current HOD Policy)
20

21 3. That AMA policy D-295.316 be amended by addition of new clause (3c) to read as
22 follows:
23

24 Our AMA: (c) encourages key stakeholders to collect and analyze data on the
25 effectiveness of management and leadership training and share such information with
26 the medical education community. (Directive to Take Action)
27

28 4. That clause (4a) of AMA policy D-295.316 be rescinded, as having been accomplished by
29 the writing of this report.
30

31 Our AMA will: (a) ~~study the extent of the impact of AMA Policy D-295.316,~~
32 ~~“Management and Leadership for Physicians,” on elective curriculum;~~ and (b) expand
33 efforts to promote the tenets of health systems science to prepare trainees for
34 leadership roles and address prevalent challenges in the practice of medicine and
35 public health. (Rescind HOD Policy)
36

37 5. That AMA policy D-295.316 be amended by addition of a new clause (5), to read as
38 follows:
39

40 Our AMA will create a central online directory of its management and leadership
41 resources that is searchable on the AMA website and promote the directory and these
42 resources to AMA members and the medical education community.
43

44
45 Fiscal note: \$1000

APPENDIX A

History and evolution of AMA Policy [D-295.316](#) prior to A-22

This policy is rooted in Resolution 918-I-14 whose genesis was inspired by the desire to build upon BOT 28-A-14, “Qualifications, Selection, and Role of Hospital Medical Directors and Others Providing Medical Management Services”; this BOT report recommended extensive amendments to Policy H-235.981.

Timeline for D-295.316:

- Substitute Resolution 918, I-14
- Appended: Res. 306, I-16
- Reaffirmed in lieu of: Res. 307, A-17
- Modified: Res. 313, A-18
- Appended: Res. 327, A-22

CLAUSE	HOD ACTION	ACCOMPLISHMENTS
<p>1. “Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.”</p>	<p>Adopted at I-14.</p> <p>This resolve from substitute Resolution 918 was adopted in lieu of original 918 at I-14. It became the first clause of D-295.316.</p>	<p>2014-2016:</p> <p>Conducted qualitative study to evaluate the market for physician leadership training and development and test potential demand for an AMA-led program. Study revealed an interest for this type of curriculum, that leadership training programs already exist, and that such programs would be best delivered to medical students and residents before they start their careers. Also determined saturation of physician leadership training market from state and specialty medical associations that offer courses, regional programs (e.g., The Physician Leadership Project), physician-specific MBAs (e.g., University of Tennessee), and membership (e.g., American Association for Physician Leadership).</p> <p>Conducted an environmental scan to identify physician-focused leadership programs offered through state and specialty associations. Findings noted several organizations offer leadership training, CME, conferences, programs, and other types of development for physicians. Many states partner with universities to offer programs. While there seems to be strong interest in “physician leadership training,” the definition and scope of this term varies. Interests range from mentoring, coaching, webinars, and</p>

		<p>certificate programs to an MBA. Likewise, topical interests range from traditional leadership topics such as management to broader issues around finance, revenue cycle, and quality outcomes.</p> <p>As a result of this research, AMA to develop leadership-related content for physicians specific to topics where the AMA has unique expertise at both at the individual and practice levels.</p> <p>In 2015, partnered with the American Association for Physician Leadership (AAPL) in a joint leadership initiative to develop multiple leadership courses and organize a large conference in early 2016. Registration for the conference was extremely low, and the event was cancelled. The partnership with AAPL was discontinued.</p>
<p>2. “Our AMA will work with key stakeholders to advocate for collaborative programs <u>among</u> medical schools, <u>residency programs</u>, and related schools of business and management to better prepare physicians for administrative, <u>financial</u> and leadership responsibilities in medical management.”</p>	<p>Adopted at I-14 and amended at A-18.</p> <p>This resolve from substitute Resolution 918 was adopted in lieu of original 918 at I-14. It became the second clause of D-295.316.</p> <p>Resolution 313 at A-18 amended this clause by addition.</p>	<p>In 2014, AMA contacted the AAMC, AOA, and AACOM to inform them of the new policy. It was also transmitted to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups via the AMA MedEd Update e-newsletter. Further, the AMA Section on Medical Schools (now called the Academic Physician Section) was encouraged to advocate on behalf of the issue.</p>
<p>3a. “Our AMA will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral <u>to achieving personal and professional financial</u></p>	<p>This clause from substitute resolution 306 was adopted in lieu of original 306 at I-16, and subsequently appended to D-295.316 as clause 3a.</p>	<p>In 2016, AMA contacted the AAMC, ACGME, and LCME to inform them of the new policy. It was also communicated to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups via an article in the AMA MedEd Update e-newsletter.</p>

<p><u>literacy and</u> leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative;”</p>	<p>Resolution 313 at A-18 amended this clause by addition.</p>	<p>In 2018, amended policy was communicated to the HOD, AMA members, and interested organizations via an AMA Wire article.</p>
<p>3b. “Our AMA will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership <u>and personal and professional financial literacy</u> capabilities.”</p>	<p>Adopted at I-16 and amended at A-18.</p> <p>This clause from resolution 306 was adopted as amended at I-16, and subsequently appended to D-295.316 as clause 3b.</p> <p>Resolution 313 at A-18 amended this clause by addition.</p>	

APPENDIX B

Relevant AMA Policy

H-235.981, Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical Management Services

1. Our AMA supports the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs:

a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.

b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO).

c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services.

d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law.

e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.

2. Our AMA supports the following guidelines regarding the role of the organized medical staff vis-a-vis individuals employed by or under contract with hospitals/health systems to provide medical management services:

a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws.

b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body.

c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.

d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.

H-405.990, Physician Managers

The AMA advocates (1) compiling and making available to interested medical students, residents, and practicing physicians information on management career opportunities and educational programs; (2) liaison activities with recognized national organizations that represent the interests of physician managers, and (3) continued efforts to collect and disseminate relevant and useful data pertaining to physician managers.

H-445.984, Training Physicians and Physicians-in-Training in the Art of Public Speaking H-445.984

1. Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA's ongoing work are invited to learn more through the AMA Ambassador program. Meanwhile, STEPS Forward provides helpful tips to physicians and physicians-in-training wanting to improve communication within their practice and AMPAC is available for physicians and physicians-in-training who want to advocate and communicate about the needs of patients, physicians, and physicians-in-training in the pursuit of public office. There are also resources provided to physicians and physicians-in-training at various Federation organizations and through the American Association of Physician Leadership (AAPL) to support those who are interested in training of this nature. Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International. The Board of Trustees recommends that the AMA's Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians and physicians-in-training learn more about public speaking.

2. Our AMA will offer live education sessions at least annually for AMA members to develop their public speaking skills.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 08-A-23

Subject: Challenges to Primary Source Verification of International Medical Graduates
Resulting from International Conflict

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 American Medical Association (AMA) Policy D-255.975, “Hardship for International Medical
2 Graduates from Russia and Belarus,” calls for the following action:

3
4 “Our AMA will study the impact of the current political crisis on international medical
5 graduates with medical degrees from Russia and Belarus who are already in the U.S. either in
6 training or practicing in regards to their ability to obtain primary source verification and report
7 back during the 2022 Interim House of Delegates meeting.”
8

9 The resolution that led to the policy was adopted at the 2022 Annual Meeting of the AMA House
10 of Delegates (HOD). This report is in response to that policy.

11
12 BACKGROUND

13
14 Russia, with the support of Belarus, invaded Ukraine on February 24, 2022. This action
15 precipitated sanctions of the invading countries by the international community, including the U.S.,
16 which significantly reduced communication to and from organizations in Belarus and Russia, to
17 include postal mail, internet, and receipt and origination of electronic payments. These gaps in
18 communications may affect international medical graduates (IMGs) in the U.S. who completed
19 medical school in Russia or Belarus, and who may require primary source verification for purposes
20 of obtaining licensure or credentialing.
21

22 One of the key organizations involved in such verification and assistance of IMGs is the
23 Educational Commission for Foreign Medical Graduates (ECFMG), a member of Intealth, an
24 integrated organization that also includes the Foundation for Advancement of International Medical
25 Education and Research (FAIMER™). Certification by ECFMG is the standard for evaluating the
26 qualifications of these physicians before they enter U.S. graduate medical education (GME).
27 ECFMG Certification also is a requirement for IMGs to take Step 3 of the three-step United States
28 Medical Licensing Examination® (USMLE®) and to obtain an unrestricted license to practice
29 medicine in the United States.
30

31 The ECFMG provides other programs for IMGs pursuing U.S. GME, including those that 1) assist
32 them with the process of applying for U.S. GME positions and 2) sponsor foreign nationals for the
33 J-1 visa for the purpose of participating in such programs. The ECFMG also offers a verification
34 service that allows GME programs, state medical boards, hospitals, and credentialing agencies in
35 the United States to obtain primary-source confirmation that their IMG applicants are ECFMG-
36 certified.¹

1 A little over a month after the invasion, on March 31, 2022, the ECFMG announced that it was
2 pausing certification services requested by Russian citizens residing in Russia.² The ECFMG
3 statement reflected concern for the health and safety of all medical school students and graduates as
4 they pursue their medical education and training. The statement also noted that 30 Russian
5 physicians and 10 Ukrainian physicians were selected in the 2022 Match for positions in U.S.
6 training programs; ECFMG noted that it would do its best to assist those seeking J-1 visas.

7 8 RELEVANT AMA POLICIES

9
10 The AMA has a number of policies reflecting support for IMGs and their significant role in
11 providing health care services in the U.S., as highlighted in the appendix. That said, AMA policy
12 does not specifically address the issue of physicians in the U.S. who are from countries that are
13 sanctioned by the international community and the resulting impact on primary source verification
14 of their medical education for the purposes of licensure, certification, and credentialing.

15
16 Existing policy D-275.989, “Credentialing Issues,” asks that the AMA encourage “state medical
17 licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept
18 the Educational Commission for Foreign Medical Graduates certification as proof of primary
19 source verification of an IMG’s international medical education credentials.” If credentialing
20 organizations follow this recommendation, that obviates the need for communication to foreign
21 schools or government agencies to obtain the requested documentation.

22 23 RELEVANT POLICY FROM THE WORLD MEDICAL ASSOCIATION

24
25 Founded in 1947, the World Medical Association (WMA) is a non-governmental, not-for-profit
26 voluntary organization representing 9 million physicians from 115 national medical associations.
27 The WMA’s areas of interest comprise ethical, educational, social, public health, and medical
28 practice concerns, among others. The AMA has a delegation to the WMA and is involved in
29 proposing and revising WMA policies, which help inform global health policy.³

30
31 A recent search of WMA policy found nothing that specifically mentions primary source
32 verification or support for IMGs from Russia and Belarus. The policy “Ethical Guidelines for the
33 International Migration of Health Workers”⁴ includes the following recommendations:

34
35 5) Physicians should not be prevented from leaving their home or adopted country to pursue
36 career opportunities in another country.

37
38 8) Nothing should prevent countries from entering into bilateral agreements and agreements
39 of understanding, as provided for in international law and with due cognizance of international
40 human rights law, so as to effect meaningful co-operation on health care delivery, including the
41 exchange of physicians.

42
43 The above policy also underscores the World Health Organization (WHO) Global Code of Practice
44 on the International Recruitment of Health Personnel,⁵ which specifies ethical and equitable
45 recruitment principles, but again no specific mention is made of primary source verification or
46 challenges to such recruitment and verification of credentials in the case of war and/or conflict.

47
48 Other tangentially relevant WMA policies include two resolutions (both adopted in October 2022)
49 on humanitarian and medical aid⁶ and support for medical personnel and citizens⁷ that specifically
50 mention the Russian invasion and the resulting impact on Ukraine.

1 DISCUSSION

2
3 Policy D-255.975 stipulates the study of IMGs “with medical degrees from Russia and Belarus
4 who are already in the U.S. either in training or practicing” in regard to concerns for primary
5 source verification of their education. The ECFMG statement, in contrast, specifically paused
6 certification services requested by Russian citizens residing in Russia (not Belarus)—it was not
7 directed at those Russian citizens already in the U.S., as described in the resolution.

8
9 In the case of the invasion of Ukraine, damages to and interruptions of the country’s technological
10 infrastructure would seem to present even greater challenges to the provision of needed documents
11 to the U.S. than those of Russia and Belarus. The resolution does not mention this aspect.

12
13 It is important to note that, if a physician is already in GME, that individual is primary source
14 verified, as such verification is a requirement for entry to GME (personal communication with
15 senior ECFMG staff, February 7, 2023). Even those IMGs arriving this year to commence GME
16 are likely to have already had their documents verified when they started the certification process
17 (which typically takes place over a three-year period). In other words, the impact on credentials
18 verification arising from any international conflict or cessation of diplomatic relations between the
19 U.S. and another country is delayed, so if the situation continues past three years, the negative
20 impacts to primary source verification rise.

21
22 ECFMG staff also indicated that the ECFMG pursues alternative options if the customary primary
23 source verification process is not workable—for example, when there is international conflict or
24 the medical school or ministry of health in a given country is not responding to ECFMG queries.
25 Through one alternative option, the applicant for ECFMG certification can request that three
26 medical school classmates or faculty who are now practicing in the U.S. swear on their U.S.
27 medical license that the applicant did indeed graduate. This process requires completion of a
28 notarized form and submission of a letter describing the facts of the matter. The ECFMG tries to
29 assist individual applicants throughout the certification process (while maintaining the integrity of
30 its procedures), to include postponement of examinations and refunding fees, where appropriate.

31
32 Because of the relatively low number of IMGs currently in U.S. GME programs from Russia,
33 Belarus, and Ukraine—217, 36, and 115, respectively, according to 2022 data from the AMA GME
34 Database—the extent of the impact of the Ukraine conflict on primary source verification is limited
35 in scope. ECFMG staff noted that, from a historical perspective, the cessation of communication
36 from Russia to any U.S. agency during the 1990s, the embargo with Cuba, and the Gulf wars in
37 Iraq and Iran presented significantly greater difficulties to obtaining primary source verification of
38 medical education. Nonetheless, due to the history of challenges associated with primary source
39 verification for IMGs, the Council on Medical Education—with input from the IMG Section—will
40 regularly engage with the ECFMG to monitor the impact of conflicts on primary source
41 verification of medical education and report back to the HOD as needed.

42
43 SUMMARY AND RECOMMENDATIONS

44
45 Even aside from international conflict and war, and public health disruptions such as the COVID-
46 19 pandemic, there are many challenges to primary source verification of IMGs. Despite the
47 internet and email technologies, the obstacles of international communication and retention of
48 appropriate educational records by countries of origin continue to present difficulties for IMGs.
49 The cessation of international bank payments and transfers, due to sanctions put in place by the
50 international community in response to the invasion, can also hinder requests for primary source
51 documentation.

1 The impacts of the war in Ukraine on primary source verification of physicians from Russia and
2 Belarus have been relatively limited—in part due to the small number of IMGs in the U.S. from
3 those countries. In addition, the ECFMG has been responsive to the situation and has in place
4 multiple alternative methods for verifying an IMG’s medical education credentials. That said, the
5 Council on Medical Education will continue to monitor this situation, as well as other conflicts or
6 wars that may delay primary source verification of IMGs’ medical education, and report back to
7 the HOD as needed.

8
9 As noted above, existing AMA policy D-275.989, “Credentialing Issues,” is the most relevant
10 policy to the question posed by the resolution and is therefore recommended for reaffirmation
11 through this report. Widespread acceptance by credentialing agencies of ECFMG certification
12 would provide relief to ECFMG-certified IMGs from any country as they seek initial or renewed
13 medical certification, licensure, or credentials in the U.S.

14
15 The Council on Medical Education therefore recommends that the following recommendations be
16 adopted and the remainder of this report be filed:

- 17
18 1. That American Medical Association (AMA) Policy D-275.989, “Credentialing Issues,” be
19 amended as follows:

20
21 Our AMA encourages state medical licensing boards, the Federation of State Medical
22 Boards, and other credentialing entities to accept ~~the Educational Commission for Foreign~~
23 ~~Medical Graduates~~ certification by the Educational Commission for Foreign Medical
24 Graduates (a member of Intealth) as proof of primary source verification of an IMG’s
25 international medical education credentials. (Modify Current HOD Policy)

- 26
27 2. That AMA Policy D-255.975, “Hardship for International Medical Graduates from Russia
28 and Belarus,” be rescinded, as having been fulfilled by this report:

29
30 ~~“Our AMA will study the impact of the current political crisis on international medical~~
31 ~~graduates with medical degrees from Russia and Belarus who are already in the U.S. either~~
32 ~~in training or practicing in regards to their ability to obtain primary source verification and~~
33 ~~report back during the 2022 Interim House of Delegates meeting.”~~ (Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

[H-255.966, “Abolish Discrimination in Licensure of IMGs”](#)

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

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

(BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21)

[H-255.988, “AMA Principles on International Medical Graduates”](#)

Our AMA supports: . . .

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. . . .

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

24. Continued study of challenges and issues pertinent to IMGs as they affect our country’s health care system and our physician workforce. . . .

(BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22)

[D-275.989, “Credentialing Issues”](#)

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

(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11 Modified: CME Rep. 1, A-21)

[H-275.978, “Medical Licensure”](#)

Our AMA . . . (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(CME Rep. A, A-87; BOT Rep. I-93-13; CME Rep. 10 - I-94; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13; Reaffirmed: BOT Rep. 3, I-14; Modified: CME Rep. 1, A-18; Appended: CME Rep. 3, I-19; Modified: CME Rep. 2, A-21)

[D-275.975, “Sharing of Medical Disciplinary Data Among Nations”](#)

Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide.

(Res. 318, A-05; Reaffirmed: CME Rep. 1, A-15)

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REPORT 09 OF THE COUNCIL ON MEDICAL EDUCATION (A-23)
The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

Resolution 201-A-22, “The Impact of Midlevel Providers on Medical Education,” was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution, which was subsequently referred by the HOD, requests that the AMA conduct several studies related to the education of physicians in interprofessional teams and the training and continuing education requirements of nurse practitioners and physician assistants.

This report, which is in response to the referral, addresses the multiple facets of the resolution, to include the challenges in studying bias in interprofessional education and developing a rigorous, statistically valid, and high-quality study suitable for publication by a peer-reviewed journal. This report concludes that such research is beyond the scope of the AMA, although the AMA can encourage investigators to study how interprofessional learning and team-building work promotes the development of physician leadership in team-based care.

This report describes the growth in team-based care and widespread adoption of the physician-led team as the preferred model for high-quality health care, underscoring the need for incorporating interprofessional principles into medical education and training. In addition, existing medical education accreditation standards related to interprofessional education in undergraduate and graduate medical education are highlighted. The report recommends that these standards be expanded and strengthened to state that physicians’ education and training make them uniquely qualified to lead the health care team, as reflected in AMA policy.

In addition, this report notes that the AMA does not directly oversee the education and training of nonphysician health care professionals, which makes adoption of Resolves 3 and 4 of the referred resolution neither feasible nor enforceable.

Relevant AMA policies are highlighted (and noted in the appendix). In particular, H-160.912, “The Structure and Function of Interprofessional Health Care Teams,” provides a road map to the appropriate interprofessional education of medical students and resident/fellow physicians to take on the pivotal responsibility of leadership of the interprofessional health care team.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 09-A-23

Subject: The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 Resolution 201-A-22, “The Impact of Midlevel Providers on Medical Education,” was authored by
2 the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022
3 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

4
5 RESOLVED, That our American Medical Association study, using surveys among other
6 tools that protect identities, how commonly bias against physician-led healthcare is
7 experienced within undergraduate medical education and graduate medical education,
8 interprofessional learning and team building work and publish these findings in peer-
9 reviewed journals (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA work with the Liaison Committee on Medical Education and
12 the Accreditation Council for Graduate Medical Education to ensure all physician
13 undergraduate and graduate training programs recognize and teach physicians that they are
14 the leaders of the healthcare team and are adequately equipped to diagnose and treat
15 patients independently only because of the intensive, regulated, and standardized education
16 they receive (Directive to Take Action); and be it further

17
18 RESOLVED, That our AMA study the harms and benefits of establishing mandatory
19 postgraduate clinical training for nurse practitioners and physician assistants prior to
20 working within a specialty or subspecialty field (Directive to Take Action); and be it
21 further

22
23 RESOLVED, That our AMA study the harms and benefits of establishing national
24 requirements for structured and regulated continued education for nurse practitioners and
25 physician assistants in order to maintain licensure to practice. (Directive to Take Action)

26
27 The resolution was subsequently referred by the HOD for a report back the House; this report is in
28 response to the referral.

29 30 BACKGROUND

31 32 *Concerns expressed by the resolution’s authors*

33
34 The resolution stipulates concerns with interprofessional education as well as the training and
35 practice of nonphysicians. For example, the authors claim that physicians are being reprimanded or
36 fired for speaking out about discrepancies between physician and nonphysician training. In
37 addition, concern is expressed about the growth in the number of graduate-level training programs
38 for nonphysicians, even though they are not required to pursue such training, as well as the lack of

1 any requirement for equivalent continuing education by nonphysicians, versus the need for
2 physicians to pursue such education to maintain board certification, state licensure, and often
3 hospital credentials. Finally, the resolution notes that midlevel providers are free to move between
4 various fields of medicine without any formal, regulated training or education, but physicians are
5 limited to the scope of their specialty of medicine by credentialing and board certification.

6
7 Note: The term “advanced practice providers,” including but not limited to nurse practitioners
8 (NPs) and physician assistants (PAs), is often used instead of “midlevel providers.” This report is
9 primarily concerned with these two fields.

10
11 *Reference Committee C testimony on the resolution*

12
13 The report of Reference Committee B at the 2022 Annual Meeting reflected the mixed testimony
14 on this item of business, including input from multiple specialties. Testimony highlighted that the
15 AMA has extensive policy on scope of practice, including support for physician-led team-based
16 care, as well as policy that medical education should prepare students to practice in physician-led
17 teams and that physician-led interprofessional education should be incorporated into medical
18 education and residency programs. Support was also expressed for interprofessional collaboration
19 and the role of nonphysicians as important members of the care team. General support was heard
20 for further studies about scope of practice, but testimony did note that the AMA already has
21 extensive information and existing resources outlining the differences in graduate education and
22 training of nonphysicians versus physicians. It was also noted that the directives in Resolution 201
23 were not feasible or could be costly to implement. In addition, the AMA does not have direct
24 authority over graduate clinical training or continuing education requirements for nonphysicians.
25 These requirements are set by each health profession’s accrediting, certifying, and licensing bodies,
26 who may not align themselves with AMA policies. For these reasons, the resolution was
27 recommended for referral by Reference Committee C; the HOD concurred with this decision.

28
29 *Council on Medical Education testimony on the resolution*

30
31 In its testimony before Reference Committee B, the AMA Council on Medical Education stated its
32 opposition to adoption of Resolution 201-A-22, noting the lack of feasibility of performing a study
33 regarding bias against physician-led teams in medical education and practice. In addition, the
34 Council noted that having such a study accepted and published in a peer-reviewed journal is
35 outside the AMA’s purview and control. Similarly, the AMA has no authority over the education or
36 licensure of other health care professionals, such that study of the education of these professionals,
37 as requested in the third and fourth resolved clauses, would be difficult to accomplish and the
38 recommendations from such a study are unlikely to be adopted by the affected professions. Finally,
39 the Council noted that its Report 5-A-22, “[Education, Training, and Credentialing Of Non-
40 Physician Health Care Professionals and Their Impact on Physician Education and Training
41 \(Resolution 305-J-21, Resolve 8\)](#),” addressed some of the issues outlined in Resolution 201-A-22.
42 This report led to AMA policy regarding learning about educational differences between
43 physicians and nonphysician health care professionals as well as supporting institutional oversight
44 of training programs of nonphysicians and their impact on medical education.

45
46 DISCUSSION

47
48 *Difficulty in fielding a study of bias in interprofessional education*

49
50 Resolve 1 of the referred resolution asks that the AMA “study, using surveys among other tools
51 that protect identities, how commonly bias against physician-led healthcare is experienced within

1 undergraduate medical education and graduate medical education, interprofessional learning and
2 team building work and publish these findings in peer-reviewed journals.” Investigators studying
3 this issue would first need to perform qualitative analyses of episodes of interprofessional learning
4 and team building work in medical education settings to describe the degree and nature of bias
5 against physician-led health care, if any. These findings would then inform surveys of medical
6 students and resident/fellow physicians of their experience with interprofessional learning and
7 team building work to determine the scope of the biases described by the qualitative research.
8 Investigators would require financial support to perform rigorous, statistically valid, high-quality
9 studies that would be accepted for publication by peer-reviewed journals. This research is beyond
10 the scope of the AMA; however, the AMA can encourage investigators to study how
11 interprofessional learning and team building work promotes the development of physician
12 leadership in team-based care.

13
14 *“Team sport:” The rise of the health care team*

15
16 Since World War II, medicine has seen the rapid development of new diagnostic, therapeutic, and
17 procedural techniques to improve the quality of patient care. Similarly, medicine has recognized
18 other factors influencing health outcomes, including population health,¹ structural and social
19 determinants of health,² and other key domains of health systems science.³ To address both the
20 rapid growth in medical science and technology and increased complexity of delivering high quality
21 health care, medicine has become increasingly specialized,⁴ with concordant expansion of
22 nonphysician members of the health care team. Accordingly, as team leader, the physician must
23 understand the appropriate role of each team member and ensure appropriate communication and
24 coordination of care for the patient’s benefit.⁵ Hospitals, academic practices, and health care
25 systems have increasingly adopted the physician-led team as the preferred model for high-quality
26 health care, highlighting the need for incorporating these principles into medical education and
27 training.

28
29 As physicians became increasingly specialized, PA and NP programs were established in the 1960s,
30 followed by the founding of the American Board of Family Medicine in 1969, to address the
31 workforce shortage in primary care. In addition, with the advances in the care of acute health
32 conditions, chronic disease management and the “new morbidities,”⁶ conditions arising from
33 social, behavioral, and developmental issues, began to dominate medical practice, demanding
34 multi-disciplinary teams to deliver high-quality care. Research on high-performing primary care
35 showed that access to primary care improved health outcomes, lowered health care spending, and
36 decreased health disparities.⁷ The benefits of high-performing primary care depend on patients
37 having a trusted, continuous relationship with a personal primary care physician who leads and
38 coordinates the patients’ health care team, also referred to as the medical home as defined in policy
39 [H-160.919](#), “Principles of the Patient-Centered Medical Home.”

40
41 Central to achieving optimal health outcomes is the need to define the role of the physician in
42 team-based care as the leader of the health care team. Because of the longer, more intensive
43 education and evaluation requirements in the medical profession compared to other health care
44 fields, a physician is the most qualified health professional to lead the care team in education and
45 practice. The AMA has extensive policy supporting physician-led team-based care and believes it
46 is appropriate to reinforce this concept within medical education, through which the privilege of
47 leadership is earned. In addition, the AMA’s ChangeMedEd initiative provides a real-life
48 laboratory for investigation of educational approaches to teach the primacy of the physician-led
49 team in medical education as the optimal model for ensuring quality of patient care.

1 *Medical education accreditation standards related to interprofessional education*

2
3 To ensure the quality of medical education and to implement recommended educational revisions in
4 response to the needs of medical students and resident/fellow physicians, as well as society and
5 patients, is a key role of accrediting bodies, including the Liaison Committee on Medical Education
6 (LCME) and Accreditation Council for Graduate Medical Education (ACGME) in undergraduate
7 and graduate medical education, respectively. Resolve 2 of the referred resolution asks the AMA to
8 “work with the Liaison Committee on Medical Education and the Accreditation Council for
9 Graduate Medical Education to ensure all physician undergraduate and graduate training programs
10 recognize and teach physicians that they are the leaders of the healthcare team and are adequately
11 equipped to diagnose and treat patients independently only because of the intensive, regulated, and
12 standardized education they receive.” Interprofessional education and practice are intended to
13 ensure that all members of the team learn to practice as part of a physician-led health care team.

14
15 Physicians, as team leaders, need to understand other members of the health care team’s roles as
16 well as their differences in education and training. Medical education should include knowledge of
17 the differences in the education and professional standards of other health professionals in the
18 health care team.

19
20 Current LCME and ACGME accreditation standards support interprofessional education. LCME
21 standards⁸ include two pertinent elements:

22
23 • 6.7 Academic Environments

24
25 The faculty of a medical school ensure that medical students have opportunities to learn in
26 academic environments that permit interaction with students enrolled in other health
27 professions, graduate and professional degree programs, and in clinical environments that
28 provide opportunities for interaction with physicians in graduate medical education
29 programs and in continuing medical education programs.

30
31 • 7.9 Interprofessional Collaborative Skills

32
33 The faculty of a medical school ensure that the core curriculum of the medical education
34 program prepares medical students to function collaboratively on health care teams that
35 include health professionals from other disciplines as they provide coordinated services to
36 patients. These curricular experiences include practitioners and/or students from the other
37 health professions.

38
39 The ACGME Common Program Requirements⁹ contain multiple references to interprofessional
40 education:

- 41
42 • Residents must demonstrate competence in . . . working in interprofessional teams to
43 enhance patient safety and improve patient care quality;
44
45 • The program must have a structure that promotes safe, interprofessional, team-based care
46
47 • Optimal patient safety occurs in the setting of a coordinated interprofessional learning and
48 working environment.

- 1 • Residents must participate as team members in real and/or simulated interprofessional
2 clinical patient safety activities, such as root cause analyses or other activities that include
3 analysis, as well as formulation and implementation of actions
4
- 5 • Residents must have the opportunity to participate in interprofessional quality improvement
6 activities
7
- 8 • Residents must care for patients in an environment that maximizes communication. This
9 must include the opportunity to work as a member of effective interprofessional teams that
10 are appropriate to the delivery of care in the specialty and larger health system.
11

12 Both sets of standards help underscore that interprofessional education is a priority in medical
13 education. That said, these standards could be expanded and strengthened to state that physicians'
14 education and training make them uniquely qualified to lead the health care team, as reflected in
15 AMA policy. In addition, it would be within the scope of the AMA to advocate for insertion of
16 qualifying modifiers in these standards where warranted—for example, inclusion of the phrase
17 “physician-led” to modify “interprofessional teams.” This report includes a recommendation to that
18 effect. Personal communication with LCME staff indicates that this change would be appropriate.
19

20 While interprofessional education is important, residency programs and their sponsoring institutions
21 need to ensure that the presence of other health professionals in the clinical setting does not
22 negatively impact resident education, including ensuring that residents have the appropriate
23 responsibility for patient care, case numbers, and case mix to prepare them for independent
24 practice. The ACGME’s Common Program Requirements state, in this regard, that “The presence
25 of other learners and other care providers, including, but not limited to, residents from other
26 programs, subspecialty fellows, and advanced practice providers, must enrich the appointed
27 residents’ education.”¹⁰ This concept is reflected in Policy H-310.913, “Physician Extenders,”
28 which notes in part that “procedural training is a critical portion of resident education and the
29 augmentation of patient care by nonphysician practitioners should not interfere with a resident's
30 ability to achieve competence in the performance of required procedures.”
31

32 *Education and training of other health professionals* 33

34 The AMA does not directly oversee the education and training of nonphysician health care
35 professionals. For several decades, beginning in the 1930s, the Council on Medical Education did
36 have oversight over accreditation of a significant number of allied health education programs
37 including physician assistants through its Committee on Allied Health Education and Accreditation,
38 or CAHEA. By the early to mid-1990s, that work was seen as outside the scope of the AMA and
39 ceased, leading to development of the Commission on Accreditation of Allied Health Education
40 Programs and other accreditation bodies to continue this essential role.
41

42 Despite this lack of direct oversight, the AMA can call on standard-setting organizations, such as
43 the American Board of Medical Specialties, to play a more active role in communicating with
44 policymakers the standards to which physicians are held, including maintenance of certification,
45 and why these standards serve as the basis for physician leadership of the health care team.
46

47 Resolves 3 and 4 of the referred resolution encompass AMA study of establishing “mandatory
48 postgraduate clinical training for nurse practitioners and physician assistants prior to working
49 within a specialty or subspecialty field” and “national requirements for structured and regulated
50 continued education for nurse practitioners and physician assistants in order to maintain licensure to
51 practice.”

1 For NPs, five different certifying bodies offer 19 different certificates in various fields of
2 medicine.¹¹ Certification is required to obtain state licensure for practice as an NP. Similarly, PAs
3 seeking to practice must obtain the PA-C certification. In addition, the National Commission on
4 Certification of Physician Assistants currently offers 10 certificates of added qualifications (CAQs)
5 in various fields (the CAQ is a voluntary credential and does not replace PA-C certification).¹² To
6 obtain one of these CAQs, a PA-C must have between 2 to 4 years of experience in the field. Since
7 2011, nearly 2,800 PA-Cs have earned CAQs in seven different specialties.

8
9 In summary, the third and fourth Resolves of the referred resolution are neither feasible nor
10 enforceable as our AMA does not have the authority or purview over post-graduate clinical training
11 or continuing education requirements for nonphysicians. These requirements are set by the
12 individual profession's accrediting, certifying, and licensing bodies. In addition, the AMA does not
13 have the ability to conduct a study on harms and benefits of additional training and certification
14 requirements for NPs and PAs to work as licensed professionals.

15 16 RELEVANT AMA POLICY

17
18 The AMA has several policies in support of interprofessional education. For example, Policy D-
19 295.934, "Encouragement of Interprofessional Education Among Health Care Professions
20 Students," specifies the phrase "physician-led" in its verbiage:

- 21
22 2. Our AMA supports the concept that medical education should prepare students for practice
23 in physician-led interprofessional teams.

24
25 In addition, the policy (most recently amended via Council on Medical Education Report 5-A-22)
26 includes language that encompasses the spirit of and obviates the need for Resolve 3 of Resolution
27 201-A-22:

- 28
29 Our AMA supports a clear mechanism for medical school and appropriate institutional leaders
30 to intervene when undergraduate and graduate medical education is being adversely impacted
31 by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

32
33 Other relevant policies are noted in the appendix, to include H-160.912, "The Structure and
34 Function of Interprofessional Health Care Teams," which uses the term "physician-led" in three of
35 its six clauses. Indeed, this policy provides a road map to the appropriate interprofessional
36 education of medical students and resident/fellow physicians to take on the pivotal responsibility of
37 leadership:

- 38
39 4. Our AMA adopts the following principles to guide physician leaders of health care teams:
40 a. Focus the team on patient and family-centered care.
41 b. Make clear the team's mission, vision and values.
42 c. Direct and/or engage in collaboration with team members on patient care.
43 d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing
44 education.
45 e. Foster a respectful team culture and encourage team members to contribute the full
46 extent of their professional insights, information and resources.
47 f. Encourage adherence to best practice protocols that team members are expected to
48 follow.
49 g. Manage care transitions by the team so that they are efficient and effective, and
50 transparent to the patient and family.

- 1 h. Promote clinical collaboration, coordination, and communication within the team to
- 2 ensure efficient, quality care is provided to the patient and that knowledge and expertise
- 3 from team members is shared and utilized.
- 4 i. Support open communication among and between the patient and family and the team
- 5 members to enhance quality patient care and to define the roles and responsibilities of the
- 6 team members that they encounter within the specific team, group, or network.
- 7 j. Facilitate the work of the team and be responsible for reviewing team members' clinical
- 8 work and documentation.
- 9 k. Review measures of 'population health' periodically when the team is responsible for the
- 10 care of a defined group.

11
12 It should also be noted that existing AMA policy supports advocacy and action to allow for
13 appropriate intervention when undergraduate and graduate medical education are adversely
14 affected by undergraduate, graduate, and postgraduate clinical training programs for nonphysicians
15 (as stated in Policy D-295.934 (6), "Encouragement of Interprofessional Education Among Health
16 Care Professions Students," which resulted from CME Report 5-A-22).

17
18 In short, the AMA has clear and extensive policy supporting physician-led team-based care, as well as
19 policy that medical education should prepare students to practice in physician-led teams and that
20 physician-led interprofessional education should be incorporated into medical education and residency
21 programs. Our AMA also supports interprofessional collaboration and the unique skills all health care
22 professionals bring to the health care team.

23 24 SUMMARY AND RECOMMENDATIONS

25
26 Resolution 201-A-22 requests that the AMA conduct several studies related to the education of
27 physicians in interprofessional teams and the training and continuing education requirements of
28 nurse practitioners and physician assistants. The Council on Medical Education would note that to
29 perform the requested investigations such that they meet the standard for peer-reviewed publication
30 would involve significant effort and resources that are beyond the scope of the AMA. While the
31 findings from such research could inform policymakers, it should be noted that the AMA does not
32 have direct oversight over nonphysician education, training, and practice to directly implement
33 changes based on such research.

34
35 Reinforcing the principle that interprofessional teams in education and practice are led by
36 physicians is within the scope of the AMA and is a key element of its work to protect patients.
37 A number of AMA policies encompass interprofessional education, such as D-295.934,
38 "Encouragement of Interprofessional Education Among Health Care Professions Students," and
39 provide the policy basis for the AMA to advocate for the physician as the leader of the health care
40 team. In addition, the AMA, through its Advocacy unit, plays an active and essential role in
41 preventing inappropriate expansion of practice among nonphysician health care professionals. Part
42 of this work is ensuring that health care teams are led by physicians and that nonphysicians have
43 requisite physician supervision. For this reason, the Council makes the recommendations below to
44 ensure use of the phrase "physician-led" to modify "interprofessional teams" in medical education
45 accreditation standards.

46
47 As noted in this report, if preparation for physician practice does not include leadership of teams as
48 a component, then this element should be incorporated into medical education. Toward this end, the
49 Council would refer interested delegates to a second report slated for the 2023 Annual Meeting,
50 Council on Medical Education Report 7-A-23, "Management and Leadership Training in Medical
51 Education." This report seeks to "study the extent of the impact of AMA Policy D-295.316,

1 'Management and Leadership for Physicians,' on elective curriculum and "expand efforts to
2 promote the tenets of health systems science to prepare trainees for leadership roles and address
3 prevalent challenges in the practice of medicine and public health."
4

5 The Council on Medical Education therefore recommends that the following recommendations be
6 adopted in lieu of Resolution 201-A-22 and the remainder of the report be filed:
7

- 8 1. That the American Medical Association (AMA) encourage appropriate medical education
9 accreditation organizations in allopathic and osteopathic medicine including the Liaison
10 Committee on Medical Education, Commission on Osteopathic College Accreditation,
11 American Osteopathic Association, and Accreditation Council for Graduate Medical
12 Education to:
13
14 A) Incorporate the phrase "physician-led" as a modifier for "interprofessional education"
15 into their relevant medical education accreditation standards, where appropriate;
16
17 B) Require education in and evaluation of competency in physician-led interprofessional
18 health care team leadership as part of the systems-based practice competency in medical
19 education accreditation standards. (New HOD Policy)
20
- 21 2. That the AMA encourage medical educators to study how interprofessional learning and
22 teamwork promote the development of physician leadership in team-based care. (New HOD
23 Policy)
24
- 25 3. Amend D-295.934 (2) by addition as follows: "Our AMA supports the concept that medical
26 education should prepare students for practice in, and leadership of, physician-led
27 interprofessional health care teams." (New HOD Policy)
28
- 29 4. That the AMA encourage medical standards-setting organizations, including the American
30 Board of Medical Specialties and its member boards, to inform policymakers of the
31 standards physicians are held to for independent practice in order to protect patients and that
32 these standards make physicians the appropriate leaders of the interprofessional health care
33 team. (Modify Current HOD Policy)

Fiscal note: \$1,000

APPENDIX: RELEVANT AMA POLICY

[D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students"](#)

1. Our AMA recognizes that interprofessional education and partnerships are a priority of the American medical education system.
2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
5. Our AMA supports the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.
6. Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

(Res. 308, A-08; Appended: CME Rep. 1, I-12; Modified: CME Rep. 1, A-22; Appended: CME Rep. 5, A-22)

[H-160.912, "The Structure and Function of Interprofessional Health Care Teams"](#)

1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
 - a. Focus the team on patient and family-centered care.
 - b. Make clear the team's mission, vision and values.
 - c. Direct and/or engage in collaboration with team members on patient care.
 - d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
 - e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
 - f. Encourage adherence to best practice protocols that team members are expected to follow.
 - g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.

- h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
- i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
- j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
- k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.

5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.

6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

(Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)

[D-35.985, "Support for Physician Led, Team Based Care"](#)

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21)

[H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner"](#)

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

- (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
- (2) The physician is responsible for managing the health care of patients in all practice settings.
- (3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
- (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
- (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
- (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
- (7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
- (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
- (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
- (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
- (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

[H-160.906, “Models / Guidelines for Medical Health Care Teams”](#)

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:

- a. The patient is an integral member of the team.
- b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
- c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
- d. Team members are expected to adhere to agreed-upon practice protocols.
- e. Improving health outcomes is emphasized by focusing on health as well as medical care.
- f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
- g. Safety protocols are developed and followed by all team members.

Teamwork:

- h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
- i. All practitioners commit to working in a team-based care model.
- j. The number and variety of practitioners reflects the needs of the practice.
- k. Practitioners are trained according to their unique function in the team.
- l. Interdependence among team members is expected and relied upon.
- m. Communication about patient care between team members is a routine practice.
- n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

- o. Physician leaders are focused on individualized patient care and the development of treatment plans.
- p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
- q. Care coordination and case management are integral to the team's practice.
- r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:

- s. Electronic medical records are used to the fullest capacity.
- t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.

- u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
- v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

(CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17)

[H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice”](#)

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.H-35.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)

[10.5, “Allied Health Professionals”](#)

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians’. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians’ relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

- (a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
- (b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
- (c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual’s scope of practice.

AMA Principles of Medical Ethics: I,V,VII

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)

[H-35.989, "Physician Assistants"](#)

1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient

care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17)

[H-160.947, "Physician Assistants and Nurse Practitioners"](#)

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

(BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

[H-310.913, "Physician Extenders"](#)

1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training.
2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.
(Res. 208, I-10; Appended: CME Rep. 8, A-13)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-23)

Introduced by: Resident and Fellow Section

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and
Medical School Education through Inclusion of Osteopathic Manual Therapy
Education

Referred to: Reference Committee C

1 Whereas, According to the American Osteopathic Association, osteopathic manipulative
2 medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors
3 of osteopathy receive to provide care that involves using the hands to diagnose, treat, and
4 prevent illness or injury; and

5
6 Whereas, The evidence basis for OMT is quite broad and spans many disease processes and
7 organ systems and supports its use as an adjunct treatment in a variety of conditions; and

8
9 Whereas, In order to train residents in osteopathic practice and principles (OPP) and
10 osteopathic manipulative treatment (OMT), faculty must be available and qualified; and

11
12 Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s
13 Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate,
14 through a formal application process, the commitment to teaching and assessing Osteopathic
15 Principles and Practice (OPP) at the graduate medical education level.”; and

16
17 Whereas, Programs must meet criteria laid out by that committee and apply for recognition¹;
18 and

19
20 Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill
21 proficiency in OMT as applicable to [their] specialty.”²; and

22
23 Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME
24 programs with osteopathic recognition out of the 4,780 available programs (roughly 5%).³;
25 therefore be it

26
27 RESOLVED, That our American Medical Association continue to support equal treatment of
28 osteopathic students, trainees and physicians in the residency application cycle and workplace
29 through continued education on the training of Osteopathic physicians (New HOD Policy); and
30 be it further

31
32 RESOLVED, That our American Medical Association encourage education on the benefits of
33 evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical
34 education of allopathic students and in primary care residencies. (New HOD Policy)

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

Received: 3/19/23

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RELEVANT AMA POLICY

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu of Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19; Reaffirmation I-22

Definition and Use of the Term Physician H-405.951

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign
Citation: Res. 214, A-19; Reaffirmation I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-23)

Introduced by: Resident and Fellow Section

Subject: Antitrust Legislation Regarding the AAMC, ACGME, NRMP,
and Other Relevant Associations or Organizations

Referred to: Reference Committee C

1 Whereas, The 1980 Sherman Antitrust Act was the first antitrust law to be signed by Congress,
2 and outlaws "every contract, combination, or conspiracy in restraint of trade," and any
3 "monopolization, attempted monopolization, or conspiracy or combination to monopolize"; and
4

5 Whereas, The Sherman Antitrust Act was later followed in 1914 by the Federal Trade
6 Commission Act which established the FTC and the Clayton Act which further defined specific
7 practices that the Sherman Act did not ban, thus comprising the three core federal antitrust laws
8 aimed to preserve the process of free market competition; and
9

10 Whereas, While these antitrust laws generally prohibit unlawful mergers and monopolistic
11 business practices, it is ultimately left to the courts to ultimately decide case by case basis of
12 legality; and
13

14 Whereas, In the current NRMP Match process, all applicants for the same training year are paid
15 the same amount as determined by the hospital system at which they Match; and
16

17 Whereas, Following *Jung vs AAMC* and the Pension Funding Equity Act of 2004, there has
18 been little change to the Matching process and residents are using other means to obtain fair
19 wages, safe working environments, and other benefits that are unable to be negotiated within
20 the current system; and
21

22 Whereas, Our American Medical Association holds multiple policies (H-383.992, H-383.990, D-
23 383.983, and D-383.990) regarding antitrust in medicine primarily with the goal of preserving
24 clinical autonomy, the patient-physician relationship, and ensuring fairness toward physicians
25 and physician-owned entities in the application of antitrust laws; and
26

27 Whereas, The Match poses significant anticompetition concerns and the procompetitive effect of
28 streamlining residency job applications and increasing percentage of position filled needs to be
29 outweighed by the anticompetitive effect of the lack of negotiation power of residents; therefore
30 be it
31

32 RESOLVED, That our American Medical Association study alternatives to the current residency
33 and fellowship Match process which would be less restrictive on free market competition for
34 applicants. (Directive to Take Action)

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

Received: 3/19/23

RELEVANT AMA POLICY

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973

Our AMA will work with:

(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:

- (a) ensure adequate Medicaid and Medicare funding for graduate medical education;
- (b) ensure adequate Disproportionate Share Hospital funding;
- (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
- (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
- (e) stabilize funding for pediatric residency training in children's hospitals;
- (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
- (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
- (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and

(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12;

Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

National Resident Matching Program Reform D-310.977

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e)

- the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
 - (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
 - (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
 - (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
 - (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
 - (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
 - (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
 - (18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
 - (19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22;

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

Citation: BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11; Reaffirmed: Res. 206, A-19;

AMA's Aggressive Pursuit of Antitrust Reform D-383.990

Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;

(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";

(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;

(4) continue to develop and publish objective evidence of the dominance of health insurers through its

comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;

(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and

(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans.

Citation: Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 09, A-18; Reaffirmed: Res. 206, A-19;

Antitrust Relief H-383.992

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.

Citation: Sub. Res. 905, I-07; Reaffirmation A-08; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: Res. 206, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-23)

Introduced by: Resident and Fellow Section

Subject: Medical School Management of Unmatched Medical Students

Referred to: Reference Committee C

1 Whereas, The U.S. faces a projected shortage of up to 124,000 physicians within the next 12
2 years affecting all medical and surgical specialties and resulting in a significant decrease in
3 access to care, especially among already underserved and rural populations¹; and
4

5 Whereas, The number of NRMP applicants have been increasing over the past two decades,
6 reaching all-time highs in the 2021 and 2022 match cycles of 48,700 and 47,675, respectively²;
7 and
8

9 Whereas, Despite increases in residency positions in the over the past two decades within the
10 NRMP from 20,598 positions in 2000 to 36,277 in 2022, the annual match rates amongst U.S.
11 MD seniors (i.e., US medical school MD candidates applying through the NRMP in their final
12 year of medical school) have remained between 92-95%, which amounts to over 1,000 U.S. MD
13 seniors going unmatched or withdrawing applications each year after accounting for the
14 Supplemental Offer and Acceptance Program (SOAP), while match rates of U.S. MD graduates
15 (i.e., MDs applying for the NRMP Match after they have graduated from medical school) has
16 consistently been between 50-60%, or over 700 MD graduates per year after accounting for the
17 SOAP and withdrawn applications²⁻⁵; and
18

19 Whereas, The rate of unmatched NRMP residency applicants has decreased from 25% to 20%
20 from 2006 to 2022, but due to increasing numbers of applicants, the total number of U.S. MD,
21 DO, and IMG applicants who were unmatched at the end of each annual application cycle has
22 remained over 4,000 since 2006²⁻⁵; and
23

24 Whereas, Medical school graduates have, on average, approximately \$240,000 in total student
25 loan debt, which has major financial implications, particularly for students unable to pursue
26 clinical careers due to not matching into a residency program⁶; and
27

28 Whereas, Some of the individual factors associated with going unmatched include not being
29 competitive in first-choice specialty, medical licensure exam scores, poor interviewing or
30 interpersonal skills, not applying/interviewing/ranking enough programs, concerns raised in the
31 Medical Student Performance Evaluation, professionalism concerns, school reputation, or poor
32 SOAP strategy⁷⁻⁹; and
33

34 Whereas, It is generally accepted that the worsening physician shortage would be better
35 ameliorated by fully trained physicians than by nurse practitioners or physician assistants, given
36 their distinctive training and advanced practitioners need for physician supervision; and
37

38 Whereas, Not matching into a residency program is generally attributed to the individual factors,
39 however, systemic factors contributing to not matching, including quality of medical school

1 education, structural racism, access to appropriate mentorship, and guidance, have been
2 understudied and underexplained¹⁰; therefore be it

3
4 RESOLVED, That our American Medical Association convene a task force of appropriate AMA
5 councils, medical education organizations, licensing and credentialing boards, government
6 bodies, impacted communities, and other relevant stakeholders to:

- 7 1. Study institutional and systemic factors associated with the unmatched medical graduate
8 status, including, but not limited to:
 - 9 a) The GME bottleneck on training positions, including the balance of entry-level
10 position and categorical/advanced positions;
 - 11 b) New medical schools and the expansion of medical school class sizes;
 - 12 c) Race, geography, income, wealth, primary language, gender, religion, ability, and
13 other structural factors;
 - 14 d) Student loan debt;
 - 15 e) Predatory business practices by medical schools, loan agencies, private equity,
16 and other groups that prioritize profit over student success rates;
 - 17 f) The context, history, and impact of past reports on the state of undergraduate
18 medical education, including the Flexner Report;
 - 19 g) The format and variations of institutional and medical organization guidance on
20 best practices to successful matching;
- 21 2. Develop best practices for medical schools and medical organizations to support
22 unmatched medical graduates, including, but not limited to:
 - 23 a) Tools to identify and remediate students at high risk for not matching into GME
24 programs;
 - 25 b) Adequate data on student success rates (e.g., by specialty), and factors
26 associated with success in matching;
 - 27 c) Medical school responsibilities to unmatched medical students and graduates;
 - 28 d) Outcomes-based tuition relief or reimbursement for unmatched students,
29 wherein, unmatched students are returned some component of their tuition to
30 ease the financial burden of being unable to practice clinical medicine;
 - 31 e) Transparent, equity-based solutions to address and ameliorate any inequities
32 identified in the match process;
 - 33 f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for
34 students at high risk for not matching;
 - 35 g) Career opportunities for unmatched U.S. seniors and US-IMGs; and
- 36 3. Require transparency from stakeholders, including medical schools, about any actions
37 taken based on the report of this task force, particularly with regard to the remediation of
38 medical students. (Directive to Take Action)

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

Received: 3/19/23

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RELEVANT AMA POLICY

National Resident Matching Program Reform D-310.977

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic

Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16;

Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22;

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19;

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;

B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;

C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Citation: Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22;

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17;

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

Our AMA will:

1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education.

Citation: CME Rep. 3, I-20; Modified: CME Rep. 01, I-22;

Residency Interview Schedules H-310.998

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.
2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the

Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Citation: Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07; Modified: Res. 302, A-14; Appended: Res. 314, A-19;

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

Citation: CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21; Modified: CME Rep. 1, A-22;

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and

serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

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

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

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

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

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

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
- Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21; Appended: Res. 202, I-22

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and

- in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
 5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
 6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
 7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
 8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
 9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
 12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
 13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22;

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number

of graduate medical education positions in specialties leading to first certification;

(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;

(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

(13) will work to augment the impact of initiatives to address rural physician workforce shortages.

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21; Reaffirmation: I-22;

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to

independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-23)

Introduced by: Medical Student Section

Subject: Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement

Referred to: Reference Committee C

- 1 Whereas, Gender-affirming care is an important and potentially life-saving aspect of health care
2 for transgender and gender diverse individuals^{1,2}; and
3
4 Whereas, Gender-affirming procedures represent an important component of gender-affirming
5 care with numerous benefits for transgender and gender diverse individuals^{3,4}; and
6
7 Whereas, Demand for gender-affirming procedures continues to increase^{5,6}; and
8
9 Whereas, A barrier to patients receiving gender-affirming procedures is the limited number of
10 providers trained to perform them^{6,7}; and
11
12 Whereas, Only 1 in 4 plastic surgery residency programs incorporate structured training for
13 gender-affirming procedures⁸; and
14
15 Whereas, Centers for Medicare and Medicaid Services determines reimbursement rates for
16 procedures based on “relative value units” which are influenced by recommendations from the
17 AMA/Specialty Society RVS Update Committee⁹; and
18
19 Whereas, Since 2014, health insurance reimbursement for gender-affirming procedures has
20 lagged considerably behind inflation¹⁰; and
21
22 Whereas, Lack of equitable reimbursement further limits the number of providers and
23 institutions willing to perform gender-affirming procedures due to lack of financial
24 sustainability¹¹; and
25
26 Whereas, Lack of equitable reimbursement has led to providers and institutions being unwilling
27 to accept particular health insurances, which creates an additional barrier to patients with these
28 insurances receiving gender-affirming procedures¹¹; and
29
30 Whereas, Existing AMA policy (H-185.927) states our AMA will “advocate for federal, state, and
31 local policies to provide medically necessary care for gender dysphoria”, but does not address
32 instances of gender-affirming care for individuals who do not have gender dysphoria nor
33 structured training for gender-affirming procedures nor reimbursement for said procedures by
34 health insurance providers¹²; and
35
36 Whereas, Existing AMA policy (H-185.950) states our AMA “supports public and private health
37 insurance coverage for treatment of gender dysphoria as recommended by the patient’s
38 physician”, but does not address instances of gender-affirming care for individuals who do not

1 have gender dysphoria nor reimbursement for gender-affirming procedures by health insurance
2 providers¹³; and
3

4 Whereas, Existing AMA policy (D-295.312) states our AMA will “advocate for policies
5 addressing the medical spectrum of gender identity to ensure access to quality health care”, but
6 does not address structured training for gender-affirming procedures nor reimbursement for said
7 procedures by health insurance providers¹⁴; and
8

9 Whereas, Existing AMA policy (H-160.991) states our AMA “is committed to taking a leadership
10 role in...encouraging the development of educational programs in LGBTQ Health”, thus
11 indicating that this policy is an extension of previously expressed values¹⁵; and
12

13 Whereas, Existing AMA policy (D-385.968) states our AMA will “oppose any attempts...to
14 restrict reimbursement for procedures and services based on physician specialty”, thus
15 indicating that this policy is an extension of previously expressed values¹⁶; therefore be it
16

17 RESOLVED, That our American Medical Association advocate for expanded structured training
18 for gender-affirming procedures by working with relevant stakeholders including but not limited
19 to the Accreditation Council for Graduate Medical Education (Directive to Take Action); and be it
20 further
21

22 RESOLVED, That our AMA advocate for equitable reimbursement of gender-affirming
23 procedures by health insurance providers, including public and private insurers. (Directive to
24 Take Action)

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

Received: 3/27/23

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13. *Removing Financial Barriers to Care for Transgender Patients*, Resolution 122-A08 AMA Annual Meeting. June 2008.

- Adopted AMA Resolution—June 2008
14. *Medical Spectrum of Gender*, Resolution 003-A17 AMA Annual Meeting. June 2017.
Adopted AMA Resolution—June 2017
 15. *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, Resolution*, CSA Rep. C, I-81 AMA Interim Meeting. November 1981.
Adopted AMA CSA Rep—November 1981
 16. *Support for Appropriate Billing and Payment Procedures by Physicians*, BOT Rep. 32-A08 AMA Annual Meeting. June 2008.
Adopted AMA BOT Rep—June 2008

RELEVANT AMA POLICY

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

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

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Citation: Res. 122; A-08; Modified: Res. 05, A-16; Reaffirmed: Res. 012, A-22;

Medical Spectrum of Gender D-295.312

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

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

Support for Appropriate Billing and Payment Procedures by Physicians D-385.968

Our AMA will oppose any attempts by federal and state legislatures, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for procedures and services based on physician specialty.

Citation: BOT Rep. 32, A-08; Reaffirmed: CMS Rep. 01, A-18;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the

need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Citation: Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming

care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
Citation: Res. 621, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Graduate Medical Education

Referred to: Reference Committee C

1 Whereas, Patients require a sufficient, well-trained supply of primary care physicians to meet
2 the nation's current and projected demand for health care services (H-200.949); and
3

4 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and
5 Human Services, is responsible for providing federal health services to American Indians and
6 Alaska Natives¹; and
7

8 Whereas, In areas where the IHS has substantial direct care obligations, the IHS physician
9 vacancy rate ranges from 21 to 46 percent²; and
10

11 Whereas, IHS officials note that the vacancies mentioned above are longstanding and thus
12 have negative effects longitudinally, including inequitable access to healthcare, decreased
13 quality of patient care, and adverse impact on employee morale²; and
14

15 Whereas, The U.S. Government Accountability Office has found that 57% of medical residents
16 stay to practice in the geographical location where they completed their graduate residency
17 training^{3,4}; and
18

19 Whereas, The IHS is the only large federal health system to lack formalized graduate medical
20 education (GME) partnerships with academic medical centers and teaching hospitals⁵; and
21

22 Whereas, Federal systems like the Veterans Health Administration have 75 years of
23 partnerships with teaching hospitals through its Office of Academic Affiliations, supporting
24 11,000 GME positions⁶; and
25

26 Whereas, The nation's \$15 billion in GME funding flows heavily to non-rural, non-American
27 Indian and Alaska Native communities⁵; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for the establishment of an
30 Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating
31 partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited
32 residency programs (Directive to Take Action); and be it further
33

34 RESOLVED, That our AMA support the development of novel graduate medical education
35 (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian
36 Health Programs. (New HOD Policy)
37

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

Received: 3/27/23

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RELEVANT AMA POLICY

Funding to Support Training of the Health Care Workforce H-310.916

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

Citation: Sub. Res. 913, I-09; Appended: Res. 917, I-15; Appended: Res. 309, I-20; Reaffirmed: Res. 305, A-21;

Securing Funding for Graduate Medical Education H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15)

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:

- (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
- (2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
- (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
- (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
- (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: CME Rep. 1, A-22; BOT Action in response to referred for decision: Res. 308, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-23)

Introduced by: Medical Student Section

Subject: Increased Education and Access to Fertility Resources for U.S. Medical Students

Referred to: Reference Committee C

1 Whereas, The Centers for Disease Control and Prevention (CDC) define infertility as the
2 inability to conceive after one year (or longer) of unprotected sex, which has an increased
3 prevalence in women aged 35 years or older¹; and
4

5 Whereas, The American College of Obstetricians and Gynecologists (ACOG) reports peak
6 fertility occurs in the late teens and early twenties and issued a committee opinion
7 acknowledging that fertility decreases drastically in a woman's early thirties^{2,3}; and
8

9 Whereas, ACOG has acknowledged advanced maternal age to be a pregnant woman who is
10 35 years of age or older and mothers considered to be of advanced maternal age have been
11 found to be at greater risk of adverse pregnancy outcomes, including chromosomal
12 abnormalities, adverse maternal outcomes, and miscarriage or stillbirth^{4,5}; and
13

14 Whereas, An increasing number of females have been enrolling in medical school over the
15 years, with 55.5% of 2021-2022 matriculants identifying as female⁶; and
16

17 Whereas, 68.5% of medical students report taking one or more gap years in between their
18 undergraduate institution and medical school in 2021 compared with 66.3% and 65.2% in
19 2020 and 2019 respectively, effectively increasing the average age of medical school
20 matriculants^{7,8,9}; and
21

22 Whereas, The percentage of students pursuing non-degree research years has increased in
23 the last 15 years, and only 81% of matriculating MD-only students graduated in 4 years, the
24 lowest percentage to date¹⁰; and
25

26 Whereas, The average age of females completing their medical training is 31 and on
27 average, the age for female physicians give birth for the first time at 32 compared to 27 for
28 non-physicians¹¹; and
29

30 Whereas, An estimated 25% of female physicians experience infertility, and the rate of
31 female physicians seeking fertility evaluation and requiring the use of reproductive
32 technology is six times higher than that of the general population^{12,13,14}; and
33

34 Whereas, The rate of miscarriage among medical and surgical residents in North America is
35 almost three times higher than that of their non-physician counterparts¹⁵; and
36

37 Whereas, Female physicians have reported that their careers significantly influenced their
38 family planning and childbearing decisions, with many delaying childbearing to achieve
39 certain career milestones or balance a less "family-friendly" specialty¹⁶; and

1 Whereas, The most comprehensive study on physician fertility to date found that nearly 55%
2 of female participants would have attempted to conceive earlier in their careers if they had
3 known the prevalence of infertility among female physicians was as prevalent an issue as it
4 is¹⁶; and

5
6 Whereas, While medical students are more knowledgeable about fertility than their non-
7 medical student counterparts, several studies have found medical trainees are
8 underprepared to address topics such as age-related fertility decline, gamete preservation,
9 and the effectiveness of assisted reproductive technologies¹⁷⁻²⁰; and

10
11 Whereas, Although 8.8% of matriculating medical students identified as gay, lesbian, or
12 bisexual and 0.7% identified as transgender or non-binary in 2019, there is little research on
13 fertility experiences among physicians of sexual and gender minority backgrounds²¹; and

14
15 Whereas, Transgender and non-binary individuals have complex fertility needs and face
16 challenges such as lack of timely information regarding gamete preservation, which may
17 further impact medical trainees in this population²²; and

18
19 Whereas, Studies show that the average cost of an in vitro fertilization (IVF) cycle is \$13,000
20 and a successful IVF pregnancy costs upwards of \$112,700²³⁻²⁵; and

21
22 Whereas, Oocyte cryopreservation is currently the gold standard for fertility preservation for
23 female patients with the estimated costs of one cycle being \$7,000-\$9,253 with a long-term
24 estimated storage cost of \$343-\$1,000 per year as of 2017²⁶⁻²⁸; and

25
26 Whereas, Sperm cryopreservation is the process of retrieving and freezing the semen
27 sample with an estimated cost for one cycle of \$745²⁶; and

28
29 Whereas, 73% of medical school graduates finished with education debt in 2021 with an
30 average of \$203,062 for those indebted, not including any accumulated undergraduate
31 debt²⁹; and

32
33 Whereas, Only seventeen states have laws that require insurers to either cover or offer
34 coverage for infertility diagnosis and treatment³⁰; and

35
36 Whereas, Coverage of fertility benefits for faculty at the top 14 U.S. Medical Schools for
37 research as defined by the U.S. News and World Reports vary widely in their application,
38 particularly for cycle and coverage limitations for IVF coverage and limited fertility
39 preservation, even in states with legislation requiring infertility diagnosis and treatment
40 coverage or options³¹; and

41
42 Whereas, AMA Policy H-420.952 supports the WHO designation of infertility as a disease
43 state with multiple etiologies requiring a range of interventions to advance fertility treatment
44 and preservation; and

45
46 Whereas, AMA Policy H-185.922 supports the coverage of gamete preservation for
47 individuals for whom a medical diagnosis or treatment modality is expected to result in loss of
48 fertility; and

1 Whereas, AMA Policy H-310.902 encourages insurance providers to cover fertility
2 preservation and infertility treatment for residents and fellows, as well as supports the
3 accommodation of those persons seeking those services and treatments; and
4

5 Whereas, Although AMA Policy H-185.990 and H-185.926 support insurance coverage for
6 the diagnosis and treatment of infertility regardless of marital status or sexual orientation,
7 there is a current lack of policy specifically addressing fertility issues among medical
8 students; therefore be it
9

10 RESOLVED, That our American Medical Association work with the Association of American
11 Medical Colleges and other appropriate organizations to develop gender- and sexual
12 minority-inclusive initiatives in medical education that raise awareness about (1) how peak
13 child-bearing years correspond to the peak career-building years for many medical students
14 and trainees; (2) the significant decline in oocyte quality and quantity and increase in
15 miscarriage and infertility rates, with increasing age in medical students and trainees; (3) the
16 high rate of infertility among medical students, trainees, and physicians; and (4) various
17 fertility preservation options and including cryopreservation of oocytes and sperm and
18 associated costs (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA work with relevant organizations to increase access to strategies
21 by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm,
22 and embryos), with associated mechanisms for insurance coverage. (Directive to Take
23 Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17;

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA advocates for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.

2. Our AMA advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.

3. Our AMA advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility and supports access to fertility preservation services for those affected.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22; Modified: Res. 224, I-22;

Reproductive Health Insurance Coverage H-185.926

Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to

promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.
Citation: Res. 804, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-23)

Introduced by: Medical Student Section

Subject: Amending AMA Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians" to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents

Referred to: Reference Committee C

- 1 Whereas, Between 2000 and 2014, 66 resident physicians died by suicide - the second most
2 prevalent cause of resident death in that time frame after neoplastic diseases¹; and
3
4 Whereas, Psychological autopsy studies of physicians show that psychiatric illnesses such as
5 depression and substance abuse contribute to suicide among physicians^{2,3}; and
6
7 Whereas, Resident physicians presenting with depression or depressive symptoms may be as
8 high as 43.2% with depressive symptoms increasing by 15.8% within a year of the onset of
9 residency training, with 28% of resident physicians experiencing a major depressive episode
10 during training⁴; and
11
12 Whereas, Medical interns have increased mean Patient Health Questionnaire (PHQ-9) depression
13 scores from baseline through first year⁵, and residents demonstrate increased suicidal ideation of
14 nearly 370% in the first three months of training⁵, as well as high rates of burnout signs⁶, which has
15 independently been associated with increased risk for depression and suicide⁷; and
16
17 Whereas, Residency program directors tend to underestimate the rates of burnout among resident
18 physicians as 43% of residents reported that the inability to take time off of work as a significant
19 barrier to seeking help⁸; and
20
21 Whereas, Screening for burnout in gynecology residents found 89.8% demonstrated moderate
22 burnout⁹, and depression screening in Otolaryngology-Head and Neck Surgery residents was
23 demonstrated to be cost effective in identifying and treating mental health⁹; and
24
25 Whereas, Tools have been developed to evaluate physician burnout including the AMA sponsored
26 Physician Well-Being Index (PWBI), which has been used to screen physicians, stratify by distress
27 level, and identify individuals likely to benefit from individualized support¹⁰, and the American
28 Foundation for Suicide Prevention (AFSP) Interactive Screening Program (ISP), a confidential,
29 anonymous, web-based stress and depression questionnaire, and subsequent counselor
30 meeting¹¹; and
31
32 Whereas, The University of California, San Diego, School of Medicine (UCSD) implemented
33 AFSP's ISP, and in the first year found that of the 374 respondents, 101 respondents and 251
34 respondents had a high risk and moderate risk for suicide, respectively, of which less than 20%
35 received treatment¹²; and

1 Whereas, UCSD implemented AFSP's ISP, and found that over the course of 7 years, 180
2 physicians and trainees at UCSD have accepted referrals for mental health care, with the majority
3 saying they would not have done so on their own¹³; and
4

5 Whereas, Institutions that rely on self-referral to establish mental health care are likely to miss
6 individuals in need as seen at Northwestern University, where 110 residents and fellows felt they
7 would benefit from mental health care, but less than half sought medical treatment¹⁴; and
8

9 Whereas, Resident physicians face barriers to accessing mental health assessments including
10 cost, time, stigma, and pervasive cultures of stoicism, even when mental health services are
11 available and free, resulting in low utilization¹⁵; and
12

13 Whereas, Opt-out/auto-enrollment strategy refers to when "a preferred behavior occurs
14 automatically but can be disregarded," contrary to opt-in/self-referral strategy where "active steps
15 must be taken to perform a preferred behavior"¹⁶; and
16

17 Whereas, Opt-out strategy makes target behavior more likely by conveying a sense of normalcy¹⁸
18 and leveraging status-quo bias, "a preference for familiarity where people tend to resist change
19 and prefer the current state of affairs"¹⁷; and
20

21 Whereas, Previous studies comparing opt-out versus opt-in methods showed opt-out strategies
22 significantly increased participation across various domains, including COVID-19 surveillance
23 testing (opt-out screening had 5.1% increased testing compared to opt-in)¹⁸, HIV testing (opt-out
24 screening had 12% increased uptake compared to opt-in)¹⁹, and colorectal screening (opt-out
25 screening had 19.5% increase screening than opt-in)²⁰; and
26

27 Whereas, Annual opt-out mental health screenings can mitigate cost, time, and stigma barriers by
28 offering "access to a no-cost evaluation in the same location and contiguous with workday time
29 slots where trainees will not have to sacrifice personal time and funds to obtain evaluation"²¹; and
30

31 Whereas, Opt-out mental health program implemented in West Virginia University (WVU) found
32 that postgraduate year 1 (PGY-1) and PGY-2 resident physicians showed a 93% attendance in
33 auto-enrolled wellness appointments, of which a majority mentioned they were "likely to return for
34 future visits if they had concerns about depression, anxiety, and burnout"²²; and
35

36 Whereas, Opt-out mental health screening implemented in WVU used "wellness days" biannually
37 where residents who participated were not required to come to work, were not required to use
38 sick/personal/vacation days, and did not bear any personal cost²²; and
39

40 Whereas, Opt-out mental health screening implemented in WVU were scheduled 1 hour visits with
41 a licensed therapist with experience with residents where all information obtained confidential (not
42 shared with administration) and stored in a separate electronic health record system²²; and
43

44 Whereas, 85% of internal medicine and internal medicine-pediatrics residents participating in an
45 opt-out mental health program at the University of Colorado (UC) agreed the program should
46 continue in the future, with the majority of interns feeling that the program positively affected their
47 wellness regardless of whether they attended the appointment²³; and
48

49 Whereas, Opt-out mental health screening implemented at UC provided "half-days" for interns
50 where students could take off half of a clinic day to meet with an in-house mental health provider,
51 or opt-out and still take off half of a clinic day²³; and

1 Whereas, Opt-out mental health screening implemented at UC was provided at no personal cost to
2 the interns and all information obtained was kept confidential²³; therefore be it
3

4 RESOLVED, That our American Medical Association policy H-295.858, "Access to Confidential
5 Health Services for Medical Students and Physicians," be amended by addition and deletion to
6 read as follows:
7

8 **Access to Confidential Health Services for Medical Students**
9 **and Physicians H-295.858**

10 1. Our AMA will ask the Liaison Committee on Medical Education, Commission on
11 Osteopathic College Accreditation, American Osteopathic Association, and
12 Accreditation Council for Graduate Medical Education to encourage medical
13 schools and residency/fellowship programs, respectively, to:

14 A. Provide or facilitate the immediate availability of urgent and emergent access to
15 low-cost, confidential health care, including mental health and substance use
16 disorder counseling services, that:

17 (1) include appropriate follow-up; (2) are outside the trainees' grading and
18 evaluation pathways; and (3) are available (based on patient preference and need
19 for assurance of confidentiality) in reasonable proximity to the education/training
20 site, at an external site, or through telemedicine or other virtual, online means;

21 B. Ensure that residency/fellowship programs are abiding by all duty hour
22 restrictions, as these regulations exist in part to ensure the mental and physical
23 health of trainees;

24 C. Encourage and promote routine health screening among medical students and
25 resident/fellow physicians, and consider designating some segment of already-
26 allocated personal time off (if necessary, during scheduled work hours) specifically
27 for routine health screening and preventive services, including physical, mental, and
28 dental care; and

29 D. Remind trainees and practicing physicians to avail themselves of any needed
30 resources, both within and external to their institution, to provide for their mental and
31 physical health and well-being, as a component of their professional obligation to
32 ensure their own fitness for duty and the need to prioritize patient safety and quality
33 of care by ensuring appropriate self-care, not working when sick, and following
34 generally accepted guidelines for a healthy lifestyle.

35 2. Our AMA will urge state medical boards to refrain from asking applicants about
36 past history of mental health or substance use disorder diagnosis or treatment, and
37 only focus on current impairment by mental illness or addiction, and to accept "safe
38 haven" non-reporting for physicians seeking licensure or relicensure who are
39 undergoing treatment for mental health or addiction issues, to help ensure
40 confidentiality of such treatment for the individual physician while providing
41 assurance of patient safety.

42 3. Our AMA encourages ~~medical schools~~ undergraduate and graduate medical
43 programs to create mental health and substance abuse awareness and suicide
44 prevention screening programs that would:

45 A. be available to all medical students, residents, and fellows on an opt-out basis

46 B. ensure anonymity, confidentiality, and protection from administrative action;

47 C. provide proactive intervention for identified at-risk students by mental health and
48 addiction professionals; and

49 D. inform students and faculty about personal mental health, substance use and
50 addiction, and other risk factors that may contribute to suicidal ideation.

51 4. Our AMA: (a) encourages state medical boards to consider physical and mental
52 conditions similarly; (b) encourages state medical boards to recognize that the

1 presence of a mental health condition does not necessarily equate with an impaired
2 ability to practice medicine; and (c) encourages state medical societies to advocate
3 that state medical boards not sanction physicians based solely on the presence of a
4 psychiatric disease, irrespective of treatment or behavior.

5 5. Our AMA: (a) encourages study of medical student mental health, including but
6 not limited to rates and risk factors of depression and suicide; (b) encourages
7 medical schools to confidentially gather and release information regarding reporting
8 rates of depression/suicide on an opt-out basis from its students; and (c) will work
9 with other interested parties to encourage research into identifying and addressing
10 modifiable risk factors for burnout, depression and suicide across the continuum of
11 medical education.

12 6. Our AMA encourages the development of alternative methods for dealing with the
13 problems of student-physician mental health among medical schools, such as: (a)
14 introduction to the concepts of physician impairment at orientation; (b) ongoing
15 support groups, consisting of students and house staff in various stages of their
16 education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical
17 and mental well-being by heads of departments, as well as other faculty members;
18 and/or (f) the opportunity for interested students and house staff to work with
19 students who are having difficulty. Our AMA supports making these alternatives
20 available to students at the earliest possible point in their medical education.

21 7. Our AMA will engage with the appropriate organizations to facilitate the
22 development of educational resources and training related to suicide risk of
23 patients, medical students, residents/fellows, practicing physicians, and other health
24 care professionals, using an evidence-based multidisciplinary approach. (Modify
25 Current HOD Policy)

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

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
 - C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
 - D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
 - A. be available to all medical students on an opt-out basis;
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and

release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22;

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
 - (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
 - (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
 - (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
 - (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
 - (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
 - (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
 - (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
 - (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
 - (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
 - (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
- Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the

signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.
Citation: CME Rep. 06, A-19; Modified: Res. 326, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-23)

Introduced by: Medical Student Section

Subject: Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants

Referred to: Reference Committee C

1 Whereas, The Deferred Action for Childhood Arrivals (DACA) program has existed since
2 2012 as a policy established by a memorandum from the Secretary of Homeland Security,
3 granting individuals who entered the United States before June 15, 2007, and who have
4 resided in the United States continuously through June 15, 2012, deferred action from
5 removal proceedings, lawful presence (but not lawful status), and employment authorization
6 for a two year period, provided that they entered the United States when they were under the
7 age of 16, and met certain criteria¹; and
8

9 Whereas, The DACA policy is on track to become codified as a federal regulation, with a final
10 rule taking effect on October 31, 2022²; and
11

12 Whereas, As of March 2022 there are 611,270 DACA recipients in the United States, with an
13 estimate of 1,159,000 considered immediately eligible without actively awarded DACA status;
14 and³
15

16 Whereas, The American Association of Medical Colleges (AAMC) estimates that over the first
17 eight years since DACA was established, only about 200 DACA-status individuals,
18 representing less than 0.1% of all DACA recipients, have trained in US medical schools and
19 residency programs⁴; and
20

21 Whereas, For the 2022-2023 school year, 70 medical institutions are listed on the AAMC
22 website as accepting DACA-status eligible applicants, 5 fewer than in 2020^{4,5}; and
23

24 Whereas, Despite institutions knowing what DACA was, only 58% were familiar with their
25 DACA admission policies⁴; and
26

27 Whereas, The Federal government permits DACA recipients to rotate through medical
28 facilities operated by the Department of Veterans Affairs (VA), and while certain states,
29 including New York and California, have expanded licensure eligibility to include DACA
30 recipients, many states restrict licensure for non-U.S. citizens who are not “qualified aliens”,
31 excluding DACA recipients from licensure⁷; and
32

33 Whereas, DACA students have reported acceptance to several institutions only to have their
34 offers rescinded due to their status, despite being transparent about their DACA status from
35 the start of the admission process⁶; and
36

37 Whereas, DACA-status students are ineligible for Federal Student Aid and must resort to
38 private student loans⁶; and

1 Whereas, The median debt of a medical school graduate is \$200,000 as of 2020, and there
2 are programs available for loan forgiveness through Public Service Loan Forgiveness, or
3 service to rural communities through the National Health Service Corps Rural Community
4 Loan Repayment Program⁶; and
5

6 Whereas, DACA recipients are ineligible for such loan forgiveness programs, despite being
7 more likely to serve in underserved and/or rural communities than the general population^{2,6};
8 and
9

10 Whereas, Less than 10% of schools reserved funds for DACA students, and some required
11 proof of payment for all four years for matriculation⁴; and
12

13 Whereas, Half of US states allow for public schools to charge DACA students out-of-state
14 tuition, despite eligibility for in-state tuition if documented⁶; and
15

16 Whereas, DACA recipients are hired through the same procedure as US Citizens or
17 Permanent Residents using the federal I-9 process⁷; and
18

19 Whereas, DACA recipients and their households pay about \$5.6 billion annually in federal
20 taxes and about \$3.1 billion annually in state and local taxes²; and
21

22 Whereas, DACA individuals are considered resident aliens for federal and state tax
23 purposes, and as such they do not qualify for government assistance programs such as
24 Supplemental Nutrition Assistance Program (SNAP), Medicaid, Supplemental Security
25 Income (SSI), Temporary Assistance for Needy Families (TANF), health insurance subsidies
26 under the Affordable Care Act (ACA), or any other federal, state, or local benefit as defined
27 by 8 U.S.C 1611 and 8 U.S.C 1621^{8,9}; and
28

29 Whereas, Our American Medical Association supports efforts to increase the applicant pool
30 of qualified minority students (H-350.979); and
31

32 Whereas, Our AMA supports that medical schools should be explicit in publications of their
33 admissions requirements and the methods they employ in the selection of students (H-
34 295.995); and
35

36 Whereas, Our AMA supports the efforts of the AAMC increasing transparency in the medical
37 school application process for international students (H-255.968); and
38

39 Whereas, Our AMA has no policy encouraging medical schools to provide transparency on
40 admissions requirements in the selection of DACA eligible applicants; and
41

42 Whereas, Our AMA supports legislation that provides targeted financial aid to financially
43 disadvantaged students at both collegiate and medical school levels (H-350.979); and
44

45 Whereas, There currently exists no similar policy for DACA-eligible medical school
46 applicants; and
47

48 Whereas, During the COVID-19 pandemic over 200,000 DACA recipients were working
49 essential positions, at least 29,000 of whom were healthcare workers¹⁰; and

1 Whereas, DACA healthcare workers increase diversity of the medical field and contribute to
2 the learning of fellow medical students to the culture of immigrant patients, broadening
3 access to care for underserved populations¹¹; and
4

5 Whereas, DACA recipients who are healthcare workers are more likely to work in
6 underserved communities, helping to alleviate a particularly dire shortage of healthcare
7 professionals in these areas; and^{2,12};
8

9 Whereas, Each DACA recipient in the healthcare field will care for an average of between
10 1,533 and 4,600 patients a year¹²; therefore be it
11

12 RESOLVED, That our American Medical Association encourage transparency from
13 institutions in the medical school application process for DACA recipients, including the
14 following and on a national level when possible: (1) the percentage of Deferred Action for
15 Childhood Arrivals applicants of total applicants, (2) the percentage of accepted Deferred
16 Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage of
17 matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants,
18 (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals
19 applicants. (New HOD Policy)
20

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

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RELEVANT AMA POLICY

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Citation: Res. 305, A-15; Appended: Late Res. 1001, I-16; Reaffirmation: A-19;

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968

Our AMA:

1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

Citation: CME Rep. 5, A-12; Reaffirmed: CME Rep. 1, A-22;

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

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

Citation: Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22;

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

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in

reaching their decisions.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-23)

Introduced by: Medical Student Section

Subject: Against Legacy Preferences as a Factor in Medical School Admissions

Referred to: Reference Committee C

- 1 Whereas, Legacy admissions are defined as a preference given by an institution to children
2 of alumni and sometimes to applicants of varying relation to alumni^{1,2}; and
3
- 4 Whereas, Legacy admissions date back to the 1920s when they were established to protect
5 universities' white, wealthy and Protestant applicants from competing with recent European
6 and Jewish immigrants¹; and
7
- 8 Whereas, Legacy admissions continue today to significantly favor the admission of white,
9 wealthy applicants, with nearly 70% of legacy applicants to Harvard identifying as white³; and
10
- 11 Whereas, 75% of the nation's major research universities and elite liberal arts college -
12 including their medical schools - factor legacy status into the decision to admit or reject an
13 applicant⁴; and
14
- 15 Whereas, 42% of private institutions - including most of the nation's elite institutions - use
16 legacy admissions^{5,6}; and
17
- 18 Whereas, Admissions data are tightly kept university secrets and ascertaining information on
19 how legacy admissions factor into the admissions process is extremely difficult⁵; and
20
- 21 Whereas, The advantage awarded by legacy status can be stark, with one study estimating
22 that legacy status provides an undergraduate applicant with the equivalent of 160 extra
23 points on the SAT and another indicating that legacy applicants are admitted at the rate of
24 more than five times non-legacy applicants^{7,8}; and
25
- 26 Whereas, In 2014, Johns Hopkins University removed legacy as a factor in admissions in
27 efforts to increase its student diversity, and subsequently from 2009 to 2019, Pell Grant
28 eligible students increased by 10%, students on financial aid increased by more than 20%,
29 and minority students increased by 10%⁹; and
30
- 31 Whereas, Johns Hopkins University attributes ending legacy admissions with building a more
32 diverse student body¹⁰; and
33
- 34 Whereas, Johns Hopkins University in 2014 and Amherst College in 2021 recently ended
35 their legacy policies^{11,12}; and
36
- 37 Whereas, Colorado banned public colleges and universities from considering legacy status in
38 the admissions process based on the conviction that providing preferential treatment to
39 students with familial relationships to alumni is discriminatory¹³; and

1 Whereas, Legislation has been introduced in Congress that ends federal funding for
2 universities that employ legacy admissions due to their ability to exacerbate racial and
3 economic inequalities¹⁴; and
4

5 Whereas, The ACLU has called for an end to legacy admissions in order to help address
6 long-standing disparities and inequality in higher education while increasing access for
7 underrepresented students¹⁵; and
8

9 Whereas, A bill was introduced by state lawmakers in New York and Connecticut in 2022 to
10 bar public and private colleges from using legacy admissions due to the impact on low
11 income students and underrepresented communities¹⁶; and
12

13 Whereas, Some experts on race, inequity, and social policy believe that legacy admissions
14 limit access for medium and low-income students as well as African American, Latino, and
15 Native American students and indefensibly provide special access to higher education to the
16 most privileged^{17,18}; and
17

18 Whereas, Physicians' children are 24x more likely to become physicians than their peers
19 making it the most inherited career requiring higher education¹⁹; and
20

21 Whereas, The most common occupation for a wealthy person, i.e. the nation's 1% of top
22 earners, is medical doctor²⁰; and
23

24 Whereas, Applicants, especially those not from medical or privileged backgrounds, face
25 numerous barriers to entry in medical school; and
26

27 Whereas, Legacy admissions have been shown to limit social mobility, making it harder for
28 disadvantaged students such as those without resources or knowledge to gain admission¹⁵;
29 and
30

31 Whereas, The University of Arizona College of Medicine guarantees an interview for legacy
32 applicants – those who have a sibling, parent or grandparent who graduated from the
33 University of Arizona College of Medicine - a privilege it offers to only 6.6% of non-legacy
34 applicants^{21,22}; and
35

36 Whereas, Most medical schools “have some sort of legacy process in place,” per the
37 University of Arizona College of Medicine’s executive director of admissions²¹; and
38

39 Whereas, Tufts University School of Medicine in April of 2021 eliminated its use of legacy
40 admissions in response to its anti-racism initiative²³; and
41

42 Whereas, The AAMC recognizes the impact of racism on all aspects of medicine, including
43 “inequitable admissions practices”²⁴; and
44

45 Whereas, The American Medical Association released a strategic plan in 2021 to dismantle
46 structural racism, address the historical inequities that marginalized populations have faced,
47 and “pivot from ambivalence to urgent action [...] and from lack of accountability to an active
48 embrace of equity as a core mission and strategy”^{25,26}; and

1 Whereas, Policy H-65.952 states that AMA recognizes racism as a serious threat to public
2 health and supports the development of policies that combat racism and its effects, but does
3 not oppose the use of legacy admissions²⁷, and
4

5 Whereas, Policy H-200.951 states that the AMA encourages medical school policies that
6 promote diversity and include underrepresented individuals in medicine, but does not oppose
7 the use of legacy admissions, which have been shown to limit racial and socioeconomic
8 diversity²⁸; and
9

10 Whereas, Policy H-350.970 states that the AMA will work with stakeholders to promote
11 programs that are aimed at increasing minority medical student admissions, but does not
12 recognize that the lack of a stance against legacy admissions contradicts this policy²⁹; and
13

14 Whereas, Policy H-295.888 states that the AMA encourages medical schools to give weight
15 to personal qualities (such as empathy, integrity, commitment to service) during the
16 admissions process, but does not have a policy stating legacy admissions are not one of the
17 personal qualities that should be considered³⁰; and
18

19 Whereas, Policy H-295.998 reaffirms the Liaison Committee on Medical Education's policy
20 about establishing effective policies and procedures in regards to medical school admissions,
21 but does not recognize that preferential legacy admissions policies fail to guarantee an
22 equitable admissions process and therefore current policies and procedures are not
23 effective³¹; and
24

25 Whereas, Legacy admissions are incompatible with the AMA's current plan to dismantle
26 structural racism by perpetuating socioeconomic and racial disparities across medical
27 institutions; therefore be it
28

29 RESOLVED, That our American Medical Association recognize that legacy admissions are
30 rooted in discriminatory practices (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA oppose the use of legacy status as a screening tool for medical
33 school admissions (New HOD Policy); and be it further
34

35 RESOLVED, That our AMA study the prevalence and impact of legacy status in medical
36 school admissions. (Directive to Take Action)
37

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

Received: 4/3/23

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

Diversity in Medical Education H-350.970

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

Citation: (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

Progress in Medical Education: the Medical School Admission Process H-295.888

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

Citation: CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21;

Due Process H-295.998

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters."

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.

Citation: CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-23)

Introduced by: Medical Student Section

Subject: Teaching and Assessing Osteopathic Manipulative Treatment and
Osteopathic Principles and Practice to Resident Physicians in the Context of
ACGME Single System of Accreditation

Referred to: Reference Committee C

- 1 Whereas, The evidence basis for osteopathic manipulative medicine/treatment (OMM/OMT) is
2 quite broad and spans across many disease processes and organ systems evidence that
3 supports its use as an adjunct treatment in a variety of conditions¹⁻⁷; and
4
- 5 Whereas, For example, there have been demonstrated improvements in symptoms of
6 menopause, perimenopause, and pregnancy by meta-analyses¹; and
7
- 8 Whereas, In a separate meta-analysis, OMT has shown benefits to both chronic low back pain
9 and acute low back pain during the peripartum and postpartum times²; and
10
- 11 Whereas, Evidence also exists showing benefits in premature neonate, pneumonia, and neck
12 pain populations³⁻⁵; and
13
- 14 Whereas, In order to train residents in osteopathic practice and principles (OPP) and
15 osteopathic manipulative treatment (OMT), faculty must be available and qualified to train these
16 residents; and
17
- 18 Whereas, Non-osteopathic faculty are unlikely to have any experience with OMT, let alone
19 sufficient expertise to train residents in the practice as multiple osteopathic professional
20 organizations and schools have to offer allopathic physicians and international medical
21 graduates a variety of paid training classes and courses to receive education on osteopathic
22 manipulation^{8,9}; and
23
- 24 Whereas, Notably, the ACGME's Osteopathic Principles Committee (ACGME-OPC), the body
25 which outlines criteria for osteopathic recognition (OR) of graduate medical education programs,
26 requires that program leadership, including a portion of faculty be certified by other professional
27 bodies in order to considered for formal osteopathic recognition¹⁰; and
28
- 29 Whereas, Those considered as acceptable faculty may include: AOA board-certified physicians;
30 a Doctor of Osteopathy with board certification through an American Board of Medical
31 Specialties; or a Doctor of Medicine graduate of an already recognized program with board
32 certification through an American Board of Medical Specialties¹⁰; and
33
- 34 Whereas, Though it is reasonable to assume that any graduate medical education program
35 seeking to properly educate residents in osteopathic manipulative medicine would need to
36 recruit faculty to leadership positions with the above qualifications, no formal studies have been
37 conducted to evaluate whether programs have adopted such requirements; and

1 Whereas, AACOM published surveys in 2015 and 2017 indicating that approximately two thirds
2 of osteopathic medical students would think more highly of programs if informed that a program
3 has OR¹¹; and
4

5 Whereas, With the recent merger into a single ACGME accreditation system, allopathic and
6 osteopathic residency programs are now available for all graduate medical students; therefore
7 be it
8

9 RESOLVED, That our American Medical Association collaborate with the Accreditation Council
10 on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and
11 any other relevant stakeholders to investigate the need for graduate medical education faculty
12 development in the supervision of Osteopathic Manipulative Treatment across ACGME
13 accredited residency programs. (Directive to Take Action)

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

Received: 4/5/23

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RELEVANT AMA POLICY

Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination H-275.929

Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician.

Citation: (Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-23)

Introduced by: Medical Student Section

Subject: Residency Application Support for Students of Low-Income Backgrounds

Referred to: Reference Committee C

1 Whereas, The Association of American Medical Colleges (AAMC) and American Association
2 of Colleges of Osteopathic Medicine (AACOM) have long offered fee assistance programs
3 (FAPs) to mitigate costs of medical school applications for students from low-socioeconomic
4 status (low-SES), though each association's FAP typically covers primary application service
5 fees and access to online databases of medical school information or interview advice¹; and
6

7 Whereas, The AAMC program goes further, subsidizing the not-insignificant prices of test
8 preparation as well as applications to ≤ 20 medical schools²; and
9

10 Whereas, These programs have been critical in increasing the number of applicants and
11 matriculants to medical school who normally face economic barriers to entering medicine³⁻⁶;
12 and
13

14 Whereas, In contrast to medical school applications, there has never been a fee assistance
15 program for the undergraduate medical education (UME) to graduate medical education
16 (GME) transition^{7,8}; and
17

18 Whereas, Applying for residency is a multi-step process with multifactorial costs, including
19 board exam fees from the National Board of Medical Examiners (NBME) and National Board
20 of Osteopathic Medical Examiners (NBOME), away rotations expenses, fees for the
21 Electronic Residency Application Service (ERAS), National Resident Matching Program
22 (NRMP), SF (ophthalmology) Match, or Urology Match, and overall interview costs^{7,8}; and
23

24 Whereas, For direct application, interview, or match costs, neither the AAMC nor NRMP
25 provide any form of financial assistance, and applicants must budget for these expenses by
26 taking out extra student loans, applying for general medical student scholarships, or incurring
27 credit card debt⁹; and
28

29 Whereas, According to a survey of M.D. students analyzed by the AAMC FIRST team in
30 December 2022, interview costs range from \$600 to \$24,000, including travel, lodging,
31 meals, etc., with a median value of approximately \$3,000¹⁰; and
32

33 Whereas, A separate survey of allopathic students found a single interview costs between
34 \$250 and \$499 and the majority of respondents spent at least \$2500 in total¹¹; and
35

36 Whereas, Costs of away rotations, often required by competitive specialties, are also borne
37 by applicants, and those who are interested in away rotations must find funding earmarked
38 visiting students¹²⁻¹⁴; and

1 Whereas, A survey of applicants in the 2014-2015 academic year found that the estimated
2 cost of a single visiting rotation was \$958, including travel, housing, and transportation¹²; and
3

4 Whereas, The same survey found that the average applicant spent around \$2000, and many
5 students spent upwards of \$5,000 and \$10,000 on visiting rotations¹²; and
6

7 Whereas, The cost of applying to away rotations with the AAMC's Visiting Student Learning
8 Opportunities (VSLO) is \$15 for each application¹⁵; and
9

10 Whereas, In H-305.925, our AMA attests that "the costs of medical education should never
11 be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given
12 specialty", which sets a foundation for financial support for medical students; and
13

14 Whereas, Our American Medical Association acknowledges the financial burden of applying
15 to residency programs in H-310.966; therefore be it
16

17 RESOLVED, That our American Medical Association advocate for residency application
18 platforms that are no-cost to all residency applicants (Directive to Take Action); and be it
19 further
20

21 RESOLVED, That our AMA support that residency and fellowship application services grant
22 fee assistance to applicants who previously received fee assistance from medical school
23 application services. (New HOD Policy)

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

Received: 4/5/23

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RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for

medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical

students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Licensing Exemptions

Referred to: Reference Committee C

1 Whereas, The Indian Health Service (IHS) is responsible for providing direct and indirect
2 healthcare services to nearly 3 million American Indians and Alaska Natives in the United
3 States¹; and
4

5 Whereas, Compared to other federal health programs like Medicaid, Medicare, and the
6 Veterans' Health Administration, the IHS is unique in that it serves members of federally
7 recognized American Indian and Alaska Native Tribes and Villages¹; and
8

9 Whereas, There are three types of healthcare facilities under the umbrella of the IHS: federal or
10 IHS (I) facilities operated by the federal government, and tribal (T) and urban (U) Indian health
11 programs which are operated under the authority and support of the Indian Self-Determination
12 and Education Assistance Act of 1975 (ISDEAA) (Public Law 93-638) and Indian Health Care
13 Improvement Act (Public Law 94-437)^{3,4}; and
14

15 Whereas, These facilities are operated through compacts and contracts with federally-
16 recognized American Indian and Alaska Native Tribes and Villages and nonprofit Indian
17 healthcare organizations^{3,4}; and
18

19 Whereas, The Affordable Care Act established that licensed health professionals employed by a
20 Tribal health program shall be exempt, if licensed in any state, from the licensing requirement of
21 the state in which the Tribal health program performs the services described in the contract or
22 compact of the Tribal health program under the authority of ISDEAA⁵; and
23

24 Whereas, Current federal law defines a "[T]ribal health program" as an Indian Tribe or Tribal
25 organization that operates any health program, service, function, activity, or facility funded, in
26 whole or part, by the Indian Health Service⁵; and
27

28 Whereas, In 2012, California Governor Jerry Brown signed Assembly Bill 1896 (AB 1896),
29 which codified the federal licensing requirement specifying that a person who is licensed as a
30 health care practitioner in any other state and is employed by a Tribal health program is exempt
31 from the respective state's licensing requirements with respect to acts authorized under the
32 person's license where the Tribal health program performs specific services, in order to help
33 align state law with federal law, make it easier to hire healthcare professionals, and fill
34 longstanding I/T/U vacancies^{6,7}; and
35

36 Whereas, In 2015, California Governor Jerry Brown took up a similar issue and signed
37 Assembly Bill 941 (AB 941) which allowed for a clinic conducted, maintained, or operated by a
38 federally recognized Indian tribe under a contract with the United States pursuant to federal law,
39 without regard to the location of the clinic, to be exempt from licensing provisions from the State
40 Department of Public Health⁸; and

1 Whereas, During the 111th Congress, the Rahall Amendment was added to H.R. 3200:
2 America’s Affordable Health Choices Act of 2009 to preserve the federal trust responsibility to
3 provide health care to American Indians and Alaska Natives and to protect the Indian Health
4 Service from inadvertent harm⁹; and
5

6 Whereas, Sec. 225 of H.R. 3200 barred any health care provider not licensed or certified under
7 State law from participating in the public health insurance option and because federal (IHS) and
8 Tribal facilities are not subject to state licensing laws, as written, Sec. 225 would have barred all
9 of these facilities from participation in a public health insurance option⁹; and
10

11 Whereas, This provides another example of why I/T/U licensing and related exemptions should
12 be considered when discussing the merits of healthcare legislation, similar to what was
13 presented by AB 1896 and AB 941 in California⁹; and
14

15 Whereas, The IHS has active policy to address the possibility that state licensing exemptions for
16 healthcare providers at I/T/U facilities may create “blindspots” allowing for physicians and other
17 healthcare professionals to practice with a restricted state license in a state not concordant with
18 their license¹⁰; and
19

20 Whereas, Without knowledge of federal statutes regarding licensing of IHS physicians and
21 facilities, state health agencies may create unnecessary burdens for filling IHS physician
22 vacancies, which average between 25 to 50 percent across the country, and licensing new
23 facilities¹¹; therefore be it
24

25 RESOLVED, That our American Medical Association advocate that physicians at Indian Health
26 Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure
27 requirements, such as requirements for state licensure when these physicians are already
28 federally licensed (Directive to Take Action); and be it further
29

30 RESOLVED, That our AMA advocate that future health reform proposals include corresponding
31 licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health
32 Program facilities and physicians to ensure that these physicians can fully participate. (Directive
33 to Take Action)

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

Received: 4/5/23

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RELEVANT AMA POLICY

Facilitating Credentialing for State Licensure D-275.994

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

Citation: Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14; Reaffirmed: Res. 215, A-22;

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-23)

Introduced by: International Medical Graduates Section

Subject: Filtering International Medical Graduates During Residency or Fellowship Applications

Referred to: Reference Committee C

- 1 Whereas, Many graduate training programs report that they receive thousands of residency
2 applications each match cycle, leading them to implement a filtering process that screens out a
3 significant number of applications based on program-specific criteria; and
4
5 Whereas, The filtering process lacks transparency and clear understanding, potentially leading
6 to unfair and biased decisions; and
7
8 Whereas, Some program directors or literature suggest that being an international medical
9 graduate is one of the first filters used, despite this not reflecting an applicant's individual merit
10 and representing a social disadvantage compared to American medical graduates; and
11
12 Whereas, Graduating from a foreign medical school doesn't reflect an applicant's individual
13 merit but rather could represent a social disadvantage compared to American medical
14 graduates; and
15
16 Whereas, It is imperative that residency applications should reflect a candidate's overall
17 academic accomplishments (standardized test results, medical school evaluations, letters of
18 recommendation, and diverse cultural background) rather than solely their IMG status used as a
19 single metric; and
20
21 Whereas, Filtering applicants based on foreign medical school training eliminates a fair and
22 equitable application process for international medical graduates and rather represents explicit
23 bias and stigma against this group of applicants; therefore be it
24
25 RESOLVED, That our American Medical Association collaborate with relevant stakeholders to
26 identify alternative methods of reducing the number of applications to review without using a
27 discriminatory filtering system that deprives international medical graduates of equitable training
28 opportunities (Direction to Take Action); and be it further
29
30 RESOLVED, That our AMA advocate for removal of the ability to filter out international medical
31 graduates during application to a residency or fellowship. (Directive to Take Action)

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

Received: 4/27/23

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2. ERAS Analytics: FAQs for Institutions | AAMC. (n.d.). AAMC. <https://www.aamc.org/services/eras-institutions/eras-analytics-faqs-institutions>

RELEVANT AMA POLICY

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-23)

Introduced by: International Medical Graduates Section

Subject: Support for International Medical Graduates from Turkey

Referred to: Reference Committee C

- 1 Whereas, The earthquake that hit Turkey on February 6, 2022, left 45,000 people dead and
2 over a million homeless; and
3
- 4 Whereas, The Turkish Enterprise and Business Confederation estimates the total cost of the
5 earthquake is \$84 billion, including \$34 billion in immediate damage, which represents 4% of the
6 country's annual economic output; and
7
- 8 Whereas, Hundreds of international medical graduates (IMGs) from Turkey have matched into
9 residency and fellowship positions, or are currently practicing physicians in many medical and
10 surgical specialties in the United States; and
11
- 12 Whereas, Immigration status is being increasingly recognized as a social determinant of health,
13 contributing to making the Turkish IMG immigrant population vulnerable, that is at increased risk
14 for psychological, social health outcomes, and financial distress, which can significantly impact
15 performance at work; and
16
- 17 Whereas, Bereavement, mental distress from losing family members and friends, financial
18 difficulty while providing support to relatives in devastated areas in Turkey, and inability to
19 provide immediate assistance to populations in dire need of help, are unique at this time for this
20 population; therefore be it
21
- 22 RESOLVED, That our American Medical Association publicly recognize and express its support
23 to immigrant physicians and trainees from Turkey (New HOD Policy); and be it further
24
- 25 RESOLVED, That our AMA acknowledge and address interpersonal and acute systemic factors
26 that negatively affect Turkish IMGs and their families (New HOD Policy); and be it further
27
- 28 RESOLVED, That our AMA affirm its support and advocate for immigrant physicians and
29 trainees working in the United States when their country of origin faces major humanitarian
30 crises, to promote an understanding of the challenges specific to immigrant physicians
31 (Directive to Take Action); and be it further
32
- 33 RESOLVED, That our AMA support the development and implementation of channels of
34 communication for immigrant physicians to share their personal and professional journey when
35 facing severe destruction, humanitarian crises, or personal losses in their country of origin,
36 contributing therefore to improving the understanding of the difficulties faced by immigrant
37 physicians. (New HOD Policy)

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

Received: 4/27/23

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Reference Committee D

BOT Report(s)

17 AMA Public Health Strategy

CSAPH Report(s)

04 School Resource Officer Violence De-Escalation Training and Certification

05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers

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

07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

08 Sunset Review of 2013 HOD Policies

Resolution(s)

401 Metered Dose Inhalers and Greenhouse Gas Emissions

402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers

405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court

406 Increase Employment Services Funding for People with Disabilities

407 Addressing Inequity in Onsite Wastewater Treatment

408 School-to-Prison Pipeline

409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs

411 Protecting Workers During Catastrophes

412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

413 Supporting Intimate Partner and Sexual Violence Safe Leave

414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population

415 Environmental Health Equity in Federally Subsidized Housing

416 New Policies to Respond to the Gun Violence Public Health Crisis

417 Treating Social Isolation and Loneliness as a Social Driver of Health

418 Increasing the Availability of Automated External Defibrillators

419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System

420 Foster Health Care

421 Prescribing Guided Physical Activity for Depression and Anxiety

422 National Emergency for Children

423 Reducing Sodium Intake to Improve Public Health

424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

EXECUTIVE SUMMARY

BACKGROUND. Given the number of requests from the House of Delegates for ongoing reports on public health-related topics as well as large national campaigns, the Board of Trustees is taking this opportunity to outline the AMA's work in public health. The intent is to provide clarity on our current efforts and priorities, with regular updates on progress.

DISCUSSION. The AMA's current priorities around public health are as follows:

1. Promote evidence-based clinical and community preventive services.
 - A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.
 - B. Help prevent cardiovascular disease (CVD) by addressing major risk factors.
 - C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and LTBI.
 - D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.
2. Respond to public health crises impacting physicians, patients, and the public.
 - A. Address the public health crisis of climate change.
 - B. Prevent firearm injuries and deaths.
 - C. Respond to emerging and reemerging infectious disease threats and prepare for future pandemics.
 - D. End the nation's drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
 - A. Strengthen physician and trainee knowledge of public health and social determinants of health.
 - B. Maintain AMA relationships with national public health organizations.
 - C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.
4. Combat the spread of misinformation and disinformation.
 - A. Make evidence-based medical and public health information accessible.
 - B. Combat public health disinformation that undermines public health initiatives.
 - C. Collaborate with scientific and health organizations to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-23

Subject: AMA Public Health Strategy

Presented by: Sandra A. Fryhofer, MD, Chair

Referred to: Reference Committee D

1 BACKGROUND

2

3 Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public
4 Health Systems” adopted by House of Delegates (HOD) at I-21 directed our American Medical
5 Association (AMA) to:

6

7 develop an organization-wide strategy on public health including ways in which the
8 AMA can strengthen the health and public health system infrastructure and report
9 back regularly on progress.

10

11 Policy D-135.966, “Declaring Climate Change a Public Health Crisis,” adopted by the
12 House of Delegates at A-22 directed our AMA to:

13

14 develop a strategic plan for how we will enact our climate change policies including
15 advocacy priorities and strategies to decarbonize physician practices and the health
16 sector with report back to the House of Delegates at the 2023 Annual Meeting.

17

18 Resolution 605-A-22, “Fulfilling Medicine’s Social Contract with Humanity in the Face
19 of the Climate Health Crisis” was referred by the House of Delegates and asked the AMA
20 to:

21

22 establish a climate crisis campaign that will distribute evidence-based information on
23 the relationship between climate change and human health, determine high-yield
24 advocacy and leadership opportunities for physicians, and centralize our AMA’s
25 efforts towards environmental justice and an equitable transition to a net-zero carbon
26 society by 2050.

27

28 Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis”
29 has also called for the AMA to:

30

31 report annually to the House of Delegates on our AMA’s efforts relating to
32 legislation, regulation, and litigation at the federal, state, and local levels to prevent
33 gun violence.

34

35 Given the number of requests from the HOD for ongoing reports on public health-related
36 topics as well as large national campaigns, the Board of Trustees is taking this
37 opportunity to outline the AMA’s work in public health, so the HOD has clarity on

1 current efforts and priorities. Our intent is to provide regular updates on the status of this
2 work to the HOD.

3
4 METHODS

5
6 This report is informed semi-structured, in-depth interviews with public health and
7 physician experts (n=17), members of the AMA Board of Trustees (n=11), and members
8 of the AMA's Senior Management Group (n=11). Public health experts had federal, state,
9 and local public health experience and were affiliated with governmental public health
10 organizations, national public health organizations, schools of public health, public health
11 foundations, and national medical specialty societies. Stakeholder organizations were
12 identified by the members of the Council on Science and Public Health (CSAPH).
13 Members of the AMA Board of Trustees were asked to participate in interviews at the
14 discretion of the Board Chair. Members of the Senior Management Group were identified
15 based on whether they reported that their work involves public health.

16
17 *What is Public Health?*

18
19 Since its founding in 1847, the AMA's mission has been "to promote the art and science
20 of medicine and the betterment of public health." Through the course of the interviews
21 conducted across stakeholders, it was clear that there are many different definitions and
22 understanding of what public health is.

23
24 According to the World Health Organization (WHO) public health is "the art and science
25 of preventing disease, prolonging life and promoting health through the organized efforts
26 of society."ⁱ Public health promotes and protects the health of people and the
27 communities where they live, learn, work and play.ⁱⁱ Public health practice is a different
28 field than clinical medicine with different motivating values, responsibilities, and goals.ⁱⁱⁱ
29 While a doctor treats people who are sick, those working in public health try to prevent
30 people from getting sick or injured in the first place. A public health professional's duty
31 is to the community rather than an individual patient.

32
33 *Connection with Health Equity*

34
35 It is important to acknowledge that health equity is a central concept in public health and
36 is essential to improving the health of populations. The WHO defines health equity as the
37 "absence of unfair and avoidable or remediable differences in health among social
38 groups."^{iv} It calls for just opportunities, conditions, resources and power for all people to
39 be as healthy as possible. Public health interventions and policies aim to reduce health
40 disparities and are essential for promoting health equity and improving the health of
41 entire populations. Opportunities and resources for health are inequitably distributed,
42 public health seeks to right this inequity.

43
44 The AMA's health equity strategy recognizes that structural and social drivers of health
45 inequities shape a person's and community's capacity to make healthy choices, noting
46 that downstream opportunities provided by the health care system and individual-level
47 factors are estimated to only contribute 20 percent to an individual's overall health and
48 well-being, while upstream opportunities of public health and its structural and social
49 drivers account for 80 percent of impact on health outcomes.^v

50

1 The five strategic approaches of the health equity strategy are highly relevant to the
2 AMA's public health work and include:

- 3
- 4 1. Embed racial and social justice throughout the AMA enterprise culture, systems,
5 policies and practices.
- 6 2. Build alliances and share power with historically marginalized and minoritized
7 physicians and other stakeholders.
- 8 3. Push upstream to address all determinants of health and the root causes of
9 inequities.
- 10 4. Ensure equitable structures and opportunities in innovation.
- 11 5. Foster pathways for truth, racial healing, reconciliation and transformation for the
12 AMA's past.
- 13

14 The AMA already develops an annual report on health equity activities. While integral to the
15 AMA's public health strategy, progress towards the health equity strategy will continue to be
16 reported in the BOT's annual health equity report. (See BOT 10-A-23, "Center for Health Equity
17 Annual Report.")

18 19 CURRENT AMA APPROACHES TO PREVENTION & PUBLIC HEALTH

20 21 **1. Promote evidence-based clinical and community preventive services.**

22
23 Clinical preventive services involve the care provided by physicians and other health care
24 professionals during a routine one-to-one encounter.^{vi} They have a strong evidence base for
25 efficacy in health improvement and/or cost-effectiveness. These services are not public health, but
26 rather clinical care. However, they are included here because they are necessary to achieve the
27 goals of public health. Community preventive services are evidence-based options that decision
28 makers and affected community members can consider when determining what best meets the
29 specific needs, preferences, available resources, and constraints of their jurisdictions and
30 constituents.^{vii} They are not oriented to a single patient or all of the patients within a practice. The
31 target is an entire population or subpopulation usually identified by a geographic area.^{viii}

32
33 A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory
34 Committee on Immunization Practices (ACIP), and the Community Preventive Services Task
35 Force (CPSTF) and support the dissemination of recommendations to physicians.

36
37 The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national
38 experts in disease prevention and evidence-based medicine. The Task Force works to improve the
39 health of people nationwide by making evidence-based recommendations about clinical preventive
40 services. The AMA is USPSTF Dissemination and Implementation (D&I) partner, through which
41 we contribute expertise by helping disseminate the work of the task force to physician members to
42 help put the recommendations into practice.^{ix} Partners are also a powerful vehicle for ensuring the
43 U.S. primary care workforce remains up to date on USPSTF recommendations.

44
45 The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health
46 experts who develop recommendations on the use of vaccines in the civilian population of the
47 United States. The recommendations stand as public health guidance for safe use of vaccines and
48 related biological products. In addition to the voting members, there are 30 non-voting
49 representatives from professional organizations, including the AMA, that are highly regarded in the
50 health field.^x These members comment on ACIP's recommendations and offer the perspectives of
51 groups that will implement the recommendations.

1 The Community Preventive Services Task Force (CPSTF) is an independent, non-federal panel
2 whose members are appointed by the CDC Director. CPSTF members represent a broad range of
3 research, practice, and policy expertise in prevention, wellness, health promotion, and public
4 health. The CPSTF was convened in 1996 by the Department of Health and Human Services
5 (HHS) to identify community preventive programs, services, and policies that increase health,
6 longevity, save lives and dollars, and improve Americans' quality of life. The CPSTF's
7 recommendations, along with the systematic reviews of the evidence on which they are based, are
8 compiled in the *The Community Guide*. The AMA serves as an organizational liaison to the
9 CPSTF.^{xi}

10
11 B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic
12 Priority led by the Improving Health Outcomes Group)

13
14 The AMA is committed to improving the health of the nation and reducing the burden of chronic
15 diseases. In collaboration with health care leaders and organizations, the AMA is developing and
16 disseminating new chronic disease prevention and management approaches. Our primary focus is
17 cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for 1 in 4
18 deaths.^{xii,xiii} The AMA engages in this work through strategic alliances with various organizations
19 including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

20
21 Two major risk factors for CVD are hypertension and type 2 diabetes. An estimated 116 million
22 adults have hypertension and 96 million have prediabetes which can lead to hypertension.^{xiv,xv}
23 Obesity also leads to the development of cardiovascular disease and cardiovascular disease
24 mortality independently of other cardiovascular risk factors.^{xvi} To help prevent Type 2 diabetes, the
25 AMA developed clinical practice tools that support the screening and managing of people with
26 prediabetes in alignment with clinical guidelines. The AMA also developed AMA MAP BP™, a
27 clinical quality improvement program that includes population dashboards and reports as well as
28 coaching, training and support for clinical teams. IHO provides the AMA MAP BP program to
29 health care delivery organizations and other collaborators to support improvement in blood
30 pressure control for patients. The AMA MAP™ framework is expanding to include management
31 for other cardiovascular disease risk factors, including cholesterol, prediabetes, and type 2 diabetes.
32 The AMA is examining how to integrate obesity into its chronic disease portfolio. It completed a
33 landscape assessment to identify existing opportunities and will convene an expert panel to review
34 recommendations from the landscape assessment to provide guidance.

35
36 Additionally, in response to the high prevalence of uncontrolled blood pressure and to support
37 physicians in managing their patients' high blood pressure, the AMA, in collaboration with the
38 American Heart Association, developed Target: BP™, a national initiative offering a series of
39 online resources, using the latest evidence-based information. Target: BP recognizes organizations
40 committed to improving blood pressure control. In 2022, the program recognized 1,309 health care
41 organizations (HCO) for their efforts in representing 49 states or U.S. territories and serving more
42 than 28 million patients, including 8.1 million people with hypertension.

43
44 Black, Latinx, Indigenous, Asian/Pacific Islanders, and other people of color are disproportionately
45 impacted by CVD risk factors and resulting morbidity and mortalities.^{xvii} To better address these
46 disparities the AMA partnered with the American College of Preventive Medicine and Black
47 Women's Health Imperative to increase Black and Latinx women's enrollment in the CDC's
48 National Diabetes Prevention Program lifestyle change program.

49
50 The AMA, along with physician groups and heart health experts, launched the Release the Pressure
51 (RTP) campaign.^{xviii} The campaign has reached over 300,000 Black women, encouraging them to

1 pledge to “know your numbers, talk with your doctor, bring your squad,” in addition to training
2 75,000 individuals to track their blood pressure via self-monitoring blood pressure tracking tools.

3
4 C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral
5 Hepatitis and latent tuberculosis (LTBI).

6
7 Through funding from the CDC, the AMA has been engaged in work on a project entitled,
8 “Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and
9 Other Healthcare Settings.” The scope of this project includes developing, piloting and launching a
10 toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and latent TB
11 infection.

12
13 As a first phase of this work, the AMA conducted in-depth interviews, virtual clinic visits and co-
14 creation groups with clinicians working in organizations where a well-defined routine screening
15 process is already in place in order to better understand best practices, key challenges and critical
16 considerations when implementing a routine screening program. The findings from these sessions
17 were synthesized and used as the framework to build out the toolkit and its key recommendations.

18
19 The toolkit consists of a series of webpages on the AMA’s corporate website. Information and
20 recommendations are organized along the screening and testing continuum and offer helpful
21 resources and best practices from the AMA, CDC and other organizations. The resources include a
22 mix of both implementation and training-related materials for the care team. It is intended to be
23 flexible, allowing an organization to follow along throughout the entire continuum to help improve
24 the end-to-end screening and testing approach or narrow in and focus on a specific stage where
25 additional guidance and support may be needed. Two versions of the toolkit are being developed—
26 one targeted to community health centers and a second to emergency departments.

27
28 In order to validate the initial iteration of the community health center toolkit that was developed,
29 the AMA conducted a pilot with a cohort of 6 community health centers across the country.^{xix} This
30 work included pilot sites implementing 2-3 toolkit recommendation during the pilot period as well
31 as participating in a series of 5 telementoring sessions with other pilot sites, with each session
32 being focused on a different section of the toolkit. A second pilot to test elements of the toolkit in
33 practice is planned to take place in the spring of 2023 with a cohort of emergency departments.
34 Following these pilots, any feedback and comments received from pilot sites will be prioritized and
35 incorporated into the toolkit before the toolkit is launched more broadly.

36
37 D. Promote evidence-based preventive services to the public in collaboration with the Ad Council
38 and other health partners.

39
40 While the AMA’s primary audience is physicians, there are limited instances where the AMA has
41 partnered on public information campaigns on select priority issues. This work has been made
42 possible through partnerships with other health-related organizations and the Ad Council. The
43 AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that
44 we have to prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.

45
46 1. Get My Flu Shot

47
48 The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu
49 season through an annual campaign to motivate more people to get vaccinated against seasonal
50 influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted
51 in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. The *Get*

1 *My Flu Shot* campaign PSAs are launched nationwide to reach people with the message that a flu
2 shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death,
3 and avoid missing work, school, or special moments with family and friends. The campaign ads
4 direct audiences to [GetMyFluShot.org](https://www.getmyflushot.org) for more information, including where to get a flu vaccine in
5 their area.

6 7 2. It's Up to You

8
9 The Ad Council and COVID Collaborative, including the AMA, led a massive communications
10 effort to educate the American public and build confidence around the COVID-19 vaccines.
11 Guided by the leading minds in science and medicine and fueled by the best talent in the private
12 sector, the COVID-19 Vaccine Education Initiative is designed to reach different audiences,
13 including communities of color who have been disproportionately affected by COVID-19. Under
14 the umbrella of the "It's Up to You" campaign, we worked to ensure that Americans have accurate
15 and timely information to answer their questions and concerns about vaccine side effects, efficacy,
16 and clinical trials. The goal being to shift the public mindset from vaccine concern to vaccine
17 confidence.

18 19 3. Do I have Prediabetes

20
21 More than one in three American adults have prediabetes and are at high risk of developing type 2
22 diabetes—a serious health condition that can lead to heart attack or stroke. Of these individuals,
23 more than 80% of people with prediabetes don't know they have it. However, the vast majority of
24 people with prediabetes can take steps to reduce their risk. Prediabetes can often be reversed
25 through weight loss, diet changes, and increased physical activity. The AMA, in collaboration with
26 the CDC developed a series of PSAs encouraging viewers to visit [DoIHavePrediabetes.org](https://www.dohaveprediabetes.org), where
27 they can take a one-minute risk test to highlight the importance of early diagnosis and speaking
28 with their physician. Over 12.5M risk tests have been completed since 2016.

29 30 4. Get Down with Your Blood Pressure

31
32 Nearly half of all American adults have high blood pressure, yet only about 1 in 4 individuals have
33 their condition under control. Because of the pandemic and persisting health inequities, there is an
34 increased risk of high blood in communities of color, particularly for Black, Hispanic/Latinx, and
35 Native American adults. The AMA and AHA "Get Down With Your Blood Pressure" campaign
36 teaches adults that self-monitoring their blood pressure is as easy as four simple steps: get it, slip it,
37 cuff it, check it. Along with talking to your health care provider about a blood pressure
38 management plan, taking these steps can decrease the incidence of stroke, heart attack, and heart
39 failure. The AMA in collaboration with the AHA maintain both [ManageYourBP.org](https://www.manageyourbp.org)
40 or [BajaTuPresion.org](https://www.bajatuPresion.org) which host tools and resources to help educate patients about the how to self-
41 monitor your blood pressure and speak to your health care provider.

42 43 **2. Responding to public health crises impacting physicians, patients, and the public.**

44
45 The AMA's public health work has also been focused around responding to public health crises.
46 These crises are often associated with significant health risk for patients, raising concerns among
47 physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's
48 response to public health crises are typically focused on (1) ensuring physicians and trainees have
49 the data and resources needed; (2) identifying evidence-based policies and interventions; (3)
50 elevating the voices of physician leaders through AMA channels and platforms; and (4) convening
51 and collaborating with stakeholders to advance priority policies and interventions.

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A. Address the public health crisis of climate change.

At 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate change a public health crisis that threatens the health and well-being of all individuals.” At I-22, the Council on Science and Public Health presented a council-initiated report on this topic “due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted.” That report noted the health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health. The report’s recommendations, which were adopted by the HOD called for a reduction in US greenhouse gas (GHG) emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. In the coming year the AMA’s priorities will be as follows:

1. Educate physicians and trainees on the health effects of climate change.

The AMA has made climate change education available via the Ed Hub™ from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). However, the AMA has not developed a CME module for physicians and trainees on climate change, that will be an area of focus over the coming year.

2. Identify and disseminate information to physicians on decarbonizing the health care sector and reducing GHG emissions.

The U.S. health sector accounts for 25 percent of global health sector emissions, the highest proportion attributable to any individual country’s health sector. The Joint Commission is in the process of convening a technical advisory panel to initiate a directional standard that encourages health systems to address reducing their own carbon footprint, and to review existing standards to be sure, explicitly, that they do not require excess consumption. With the goal of reducing U.S. GHG emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, the AMA will create a resource page to share information on high-impact actions needed to decarbonize the health care sector.

There are several resources that already exist including Health Care Without Harm’s Road Map that provides a plan to get health care toward zero emissions.^{xx} The Road Map identifies seven high-impact actions as key to health care decarbonization. Agency for Healthcare Research and Quality (AHRQ) and Institute for Healthcare Improvement’s primer that offers guidance on high-priority measures and strategies for health care organizations to reduce their carbon footprint.^{xxi} The primer describes six domains contributing to GHG emissions in health care: building energy, transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and food. To meaningfully track and reduce GHG emissions, the primer recommends health care organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized standard for quantifying and reporting on emissions. The National Academy of Medicine’s Action Collaborative on Decarbonizing the U.S. Health Sector has also hosted a series of Carbon Clinics designed for health care delivery organizations to learn about carbon accounting. The Carbon Clinics will soon be made public along with related resources.

3. Elevate the voices of physician leaders on the issue of climate change and health.

1
2 Through the AMA’s video updates and podcast series, we amplify physician voices and highlight
3 developments and achievements throughout medicine. On January 20, 2022, the AMA featured
4 Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who
5 discussed research on the intersection of health and the climate crisis.^{xxiii} On August 25, 2022, the
6 AMA featured Colin Cave, MD, medical director of external affairs, government relations and
7 community health, Northwest Permanente to discuss the link between health and climate change,
8 and how physicians and health systems can be a part of the solution.^{xxiii} The AMA will continue to
9 look for opportunities to highlight physicians doing this important work.

10
11 4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

12
13 Medical Society Consortium on Climate and Health. The AMA will continue to engage in the
14 Medical Society Consortium on Climate and Health (Consortium), which brings together
15 associations representing over 600,000 clinical practitioners to carry three simple messages:

- 16
17 A. Climate change is harming Americans today and these harms will increase unless we act;
18 B. The way to slow or stop these harms is to decrease the use of fossil fuels and increase
19 energy efficiency and use of clean energy sources; and
20 C. These changes in energy choices will improve the quality of our air and water and bring
21 immediate health benefits.^{xxiv}

22
23 The Consortium recognizes that medical societies have an important opportunity to weigh in to
24 help ensure that the health risks of climate change and the health benefits of climate solutions,
25 especially clean energy, are clearly understood. The voices of America’s medical societies have the
26 potential to help reframe the dialogue – putting human health and wellbeing front and center in the
27 conversation. This is especially important to communities who are experiencing a disproportionate
28 impact from climate change.

29
30 National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector.

31 The AMA is also a member of the National Academy of Medicine Action Collaborative on
32 Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health
33 Care Delivery Workgroup. The Climate Collaborative is a public-private partnership of leaders
34 from across the health system committed to addressing the sector’s environmental impact while
35 strengthening its sustainability and resilience. The Climate Collaborative provides a neutral
36 platform for its participants to align around collective goals and actions for decarbonization, based
37 on evidence, shared solutions, and a commitment to improve health equity.^{xxv}

38
39 In the first year of the Climate Collaborative, the Health Care Delivery Workgroup has focused on
40 the following goals:

- 41
42 • Goal 1: Make the multi-faceted case for health systems and hospitals to minimize their
43 carbon footprints and operate more sustainably;
44 • Goal 2: Identify a set of policy and regulatory barriers preventing progress on
45 decarbonization and resilience from accelerating, and identify solutions;
46 • Goal 3: Identify a core set of sustainability metrics for hospitals and clinical practice;
47 • Goal 4: Develop decarbonization playbooks and best practices for hospitals and health care
48 delivery institutions, leveraging existing frameworks and success stories.

49
50 At the time of this report, the Health Care Delivery Workgroup is in the final stages of building
51 consensus around goals for 2023.

1
2 Healthy Air Partners. The AMA has joined the American Lung Association’s Healthy Air Partners
3 campaign, which is a coalition of 40 national public health, medical, nursing and health care
4 organizations engaged in healthy air advocacy efforts.^{xxvi} The Coalition is united in its calling for
5 strong federal laws and policies to slash air pollution and address climate change, recognizing
6 climate change can affect air quality, and certain air pollutants can affect climate change. So far in
7 2023, the AMA has joined partners on a letter to the EPA urging them to quickly strengthen and
8 finalize the Standards of Performance for New, Reconstructed, and Modified Sources and
9 Emissions Guidelines for Existing Sources: Oil and Natural Gas Sector so that implementation can
10 begin and communities can begin to see the benefits of the pollution reductions.^{xxvii}

11
12 The Inflation Reduction Act (IRA), which was signed into law on August 16, 2022, was the most
13 significant measure ever adopted by the U.S. Congress to combat climate change. The IRA is likely
14 to play an important role in mitigating the adverse health effects of climate change. Implementation
15 of the IRA will require extensive rulemaking; therefore, we anticipate that to be the focus of our
16 advocacy efforts in the coming year.

17
18 B. Prevent firearm injuries and deaths.

19
20 In the 1980’s the AMA recognized firearms as a serious threat to the public's health as the weapons
21 are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual
22 Meeting, following the Pulse nightclub shooting, policy was adopted declaring that “gun violence
23 represents a public health crisis which requires a comprehensive public health response and
24 solution.” Since that time firearm injuries and deaths have increased and disparities have
25 widened.^{xxviii}

26
27 1. Educate physicians on how to counsel at risk patients on firearm injury prevention and what
28 steps to take if a patient is at risk.

29
30 In 2018, the AMA created a CME module with physician experts on “The Physician’s Role in
31 Firearm Safety.” The learning objectives of the module are as follows: (1) Describe the
32 epidemiology of firearm morbidity and mortality in the U.S.; (2) Recognize common risk factors
33 that elevate the potential for firearm injury; (3) Identify barriers to communicating with patients
34 about firearm safety; (4) Determine practical approaches to prepare for firearm safety counseling;
35 and (5) Effectively communicate how to reduce the risk of firearm injury and death.^{xxix} The module
36 had 619 completions from 2019 - 2023 and has an overall quality rating of 4.4/5.0. The AMA is
37 currently in the process of updating the information in the module and will add a new case study
38 around dementia and firearms. The updated version is expected to launch in May of 2023. We
39 recognize that a broader dissemination strategy of the updated module will be necessary to improve
40 uptake among health care professionals.

41
42 Along with the updated CME, the AMA will launch an online tool to provide physicians with state-
43 specific laws in their jurisdiction related to counseling restrictions, safe storage and child access
44 protection laws, temporary transfer requirements, and extreme risk protection orders. This
45 information will help guide physicians when they identify patients at risk of firearm injury and
46 death by sharing details on what is allowed under state law.

47
48 2. Advocate for common sense policies to prevent firearm injuries and increased funding for
49 research.

50
51 Congress succeeded in passing the first major firearm legislation in over 30 years with

1 S. 2938, the “Bipartisan Safer Communities Act” (Murphy, D-CT/Cornyn, R-TX), which the AMA
2 supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair
3 Sandra Adamson Fryhofer, MD, attended the signing ceremony. Key provisions of the bill
4 include:

- 5
- 6 • Providing grants for states to establish or strengthen extreme risk protection orders;
- 7 • Adding convicted domestic violence abusers in dating relationships to the National Instant
8 Criminal Background Check System (NICS);
- 9 • Requiring the NICS to contact authorities to see whether an individual under the age of 21
10 has a “disqualifying” juvenile record for buying a firearm;
- 11 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited
12 from doing so; and
- 13 • Including new spending for school security and mental health treatment.
- 14

15 Our AMA is now focused on advocating to ensure that the new funding authorized in the new law
16 is actually appropriated, advocating for states to establish or strengthen extreme risk protection
17 orders, and ensuring that the other provisions are properly and quickly implemented. Pursuant to
18 the new law, the Department of Justice recently awarded over \$200 million in grants to states,
19 territories, and the District of Columbia to fund state crisis intervention court proceedings,
20 including but not limited to, extreme risk protection order (ERPO) programs that work to keep
21 guns out of the hands of those who pose a threat to themselves or others.

22
23 The AMA has also advocated for Congress to appropriate increased funding for research to prevent
24 firearm violence. The AMA is working with medical specialties, including the American Academy
25 of Pediatrics, to support \$60 million in funding for the CDC and the National Institutes of Health
26 (NIH) to conduct public health research on firearm morbidity and mortality prevention. This would
27 double the amount of funding provided last year. Our AMA will continue to monitor appropriations
28 developments and advocate to ensure that this funding is approved by Congress.

29
30 Through the AMA’s litigation center, we work to represent the interests of the medical profession
31 on this issue in the courts by providing support or becoming actively involved in litigation of
32 importance to physicians. The AMA has created a website broadly outlining the organization’s
33 advocacy efforts on gun violence prevention, this includes cases for which the AMA has filed
34 amicus briefs.^{xxx}

35
36 3. Elevate the voices of physician leaders on the issue of firearm injury and violence prevention.

37
38 Through the AMA’s video updates and podcast series, we amplify physician voices and highlight
39 developments and achievements throughout medicine. In June of 2022, the AMA featured Megan
40 Ranney MD, MPH, a practicing emergency physician, researcher and national advocate for
41 innovative approaches to public health at Brown University, talking about gun violence and why
42 we need to approach it as a public health issue with physicians playing an important role.^{xxxii} On
43 February 23, 2023, Emmy Betz, MD, MPH, professor of emergency medicine and director of the
44 Firearm Injury Prevention Initiative at the University of Colorado School of Medicine was featured
45 to discuss firearm-related injury and suicide and the role physicians can play in helping to prevent
46 it.^{xxxiii} AMA leaders, including Immediate Past President Gerald Harmon, MD, have also talked
47 about firearm injuries and deaths being a public health crisis that can affect everybody and that
48 requires a comprehensive public health response and a solution.^{xxxiii}

49

1 4. Collaborate across the federation of medicine and with other interested partners to address the
2 public health crisis of firearm injuries and deaths with a unified voice.

3
4 American Foundation for Firearm Injury Reduction in Medicine. The AMA is a partner
5 organization of AFFIRM at The Aspen Institute, which is a non-profit dedicated to ending the
6 American firearm injury epidemic using a health-based approach. AFFIRM combines the health
7 expertise with the knowledge and traditions of responsible firearm stewardship to achieve
8 consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries and
9 deaths. AFFIRM at The Aspen Institute also builds partnerships with non-medical organizations
10 that are equally committed to preventing firearm injury, including groups committed to firearm
11 safety and shooting sports.

12
13 ACP-Led Call to Action on Firearm-Related Injury and Death. The AMA has joined the American
14 College of Physicians (ACP), American Academy of Family Physicians, American Academy of
15 Pediatrics, American College of Surgeons (ACS), American Psychiatric Association, and the
16 American Public Health Association in calling for policies to help stem firearms-related injuries
17 and deaths in the United States. The organizations endorsed the article, "Firearm-Related Injury
18 and Death in the United States: A Call to Action From the Nation's Leading Physician and Public
19 Health Professional Organizations."^{xxxiv}

20
21 Medical Summits and Coalition for Firearm Injury Prevention. The AMA also participated in a
22 2019 meeting on firearm violence organized by ACS and participated in a follow-up Medical
23 Summit on Firearm Injury Prevention sponsored by ACS in collaboration with the ACP, the
24 American College of Emergency Physicians, and the Council of Medical Specialty Societies in
25 September of 2022. The objectives of the 2022 summit were to use a consensus-based, non-
26 partisan approach to selecting recommendations for executive action and/or legislation at the
27 federal, state, and municipal levels that would decrease firearm-related injuries and identify
28 elements of the most effective programs that can be implemented by physician
29 practices/clinics/hospitals/health systems in partnership with their communities to effectively lower
30 the risk of violence, with an emphasis on marginalized communities that are disproportionately
31 impacted by violence. The Summit included representatives from 46 organizations, making it one
32 of the largest gatherings of medical and injury prevention professionals on this issue. The
33 proceedings of the Summit were published in the *Journal of the American College of Surgeons*.^{xxxv}
34 To achieve the goals outlined at the Summit, the sponsoring organizations agreed to establish the
35 Healthcare Coalition for Firearm Injury Prevention.^{xxxvi}

36
37 AMA convened task force. On February 27, 2023, the AMA convened Phase I of the gun violence
38 task force, which consisted of those Federation members who have been most highly engaged on
39 the issue of firearm injury prevention for many years. Representatives from the American
40 Academy of Family Physicians, American Academy of Pediatrics, American College of
41 Emergency Physicians, American College of Physicians, American College of Surgeons, American
42 Psychiatric Association met with members of the AMA Board and staff. AMA Board Chair Sandra
43 Adamson Fryhofer, MD, Chair of the first phase of this Task Force, led the meeting. The goal was
44 to better understand work already underway to address this issue, what has worked well, and the
45 unique role an AMA convened task force could play. Gun violence advocacy organizations (Brady,
46 Giffords, and the Johns Hopkins Center for Gun Violence Solutions) were also invited to share
47 their perspectives on the role of physicians and organized medicine in firearm injury prevention.
48 The advocacy groups strongly encouraged organized medicine to pick one or two things to focus
49 on and to speak on them with a unified voice.

50
51 C. Respond to emerging and reemerging infectious disease threats and prepare for future pandemics.

1
2 Infectious diseases continue to be a threat to the U.S. population. Although some diseases have
3 been conquered by modern advances such as antibiotics and vaccines, new ones are constantly
4 emerging, whereas others reemerge in drug-resistant forms (e.g., malaria, tuberculosis, and
5 bacterial pneumonias). Because no one knows what new diseases will emerge, the health system
6 must be prepared for the unexpected. Because the AMA is relied upon as a source of information
7 by physicians and patients, the AMA has to maintain a level of capacity to respond and share
8 information and advocate for physicians, patients, and the public in line with AMA policies. Over
9 the course of the past few years, this work has focused heavily on responding to the COVID-19
10 pandemic and the outbreak of monkeypox (mpox).

11
12 1. Educate physicians on how to protect themselves and their patients from infectious disease
13 threats.

14
15 The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for
16 Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats
17 to meet the diverse learning needs and preferences of the health care workforce.^{xxxvii} Resources are
18 designed to empower and enable health care professionals to think critically about infection
19 control, using adult learning principles, educational best practices, CDC recommendations, and the
20 science that informs them. Project Firstline encourages all health care professionals to take
21 advantage of these free infection control training resources – that were developed with health care
22 professionals, specifically for health care professionals. For COVID-19 and mpox, the AMA also
23 developed resource centers to share information on testing, therapeutics, and vaccines along with
24 the latest clinical information.

25
26 2. Address preparedness for future infectious disease outbreaks and pandemics.

27
28 With over 1,000,000 individuals in the U.S. who have died as a result of COVID-19, it is critical
29 that we evaluate shortcomings and successes and provide evidence-based guidelines to protect our
30 patients and the public from COVID-19 and other future infectious pathogens. Given the
31 challenges that patients, physicians, hospitals, health care facilities, and our communities have
32 endured and continue to experience, we need to work to remedy the problems experienced during
33 the COVID-19 pandemic regarding effective testing strategies, timely directives on appropriate
34 utilization of public health mitigation strategies, evidence-supported efforts to maintain strategic
35 stockpiles of personal protective equipment, ventilators, and other supplies, and to inform future
36 health system preparedness.

37
38 D. End the nation's drug overdose epidemic.

39
40 Ending the nation's drug overdose epidemic will require increased physician leadership, a greater
41 emphasis on overdose prevention and treatment, and better coordination and amplification of the
42 efforts and best practices already occurring across the country.

43
44 1. Educate physicians on overdose prevention, substance use treatment, and pain management.

45
46 The AMA makes education available to physicians on this topic via the AMA Ed HubTM to help
47 physicians gain critical knowledge around acute and chronic pain management, substance use
48 treatment, overdose prevention, and pain treatment. Courses are both developed by AMA as well as
49 by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS),
50 which is made up of a coalition of major health care organizations all dedicated to addressing this
51 health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides

1 evidence-based training and resources to give health care providers the skills and knowledge they
2 need to treat patients with opioid use disorders and chronic pain.^{xxxviii}

3
4 2. Promote consistency in overdose-related outcome data and increase awareness for the need of
5 standardized state-level data.

6
7 The AMA has also developed an End the Epidemic Dashboard which compiles state-level data for
8 several indicators, including overdose mortality, non-fatal overdoses, opioid prescriptions, and
9 prescription drug monitoring program queries.^{xxxix} The dashboard also highlights which states are
10 missing data for any of the indicators. The goal of this dashboard is to continue to promote
11 consistency in overdose-related outcome data and increase awareness for the need of standardized
12 state-level data.

13
14 3. Convene the AMA Substance Use and Pain Care Task Force to advance evidence-based
15 recommendations for policymakers and physicians, including harm reduction strategies.

16
17 In 2015, the American Medical Association convened more than 25 national, state, specialty and
18 other health care associations to develop industry-wide recommendations for physicians to help
19 end the nation's opioid epidemic. In 2019, the AMA Pain Care Task Force highlighted efforts
20 needed to help patients with pain. In 2021, the AMA joined the two task forces to address the
21 changing—and worsening—drug overdose epidemic, emphasizing tangible actions needed to
22 increase access to evidence-based care for patients. The task force, under the leadership of Bobby
23 Mukkamala, MD, Immediate Past Chair of the AMA Board of Trustees, continues to advance
24 evidence-based recommendations for policymakers and physicians to help end the nation's drug-
25 related overdose epidemic. The task force recommendations are largely focused in the health care
26 sector, addressing access to treatment.^{xl} Recommendation 4 is focused on public health and harm
27 reduction.

- 28
29 • Recommendation 1: Support patients with pain, mental illness or a substance use disorder
30 (SUD) by building an evidence-based, sustainable and resilient infrastructure and health
31 care workforce.
32 • Recommendation 2: Remove barriers to evidence-based treatment for SUDs, cooccurring
33 mental illness and pain.
34 • Recommendation 3: Support coverage for, access to, and payment of comprehensive,
35 multi-disciplinary, multi-modal evidence-based treatment for patients with pain, a
36 substance use disorder or mental illness.
37 • Recommendation 4: Broaden public health and harm reduction strategies to save lives from
38 overdose, limit the spread of infectious disease, eliminate stigma and reduce harms for
39 people who use drugs and other substances.
40 • Recommendation 5: Improve stakeholder and multi-sector collaboration in an effort to
41 ensure that the patients, policymakers, employers, and communities benefit from evidence-
42 based decisions.

43
44 The AMA develops an annual report on the overdose epidemic outlining accomplishments and
45 what still needs to be done.^{xli}

46
47 4. Collaborate with external stakeholders to address the opioid addiction crisis.

48
49 The AMA is a member of the National Academy of Medicine (NAM) Action Collaborative on
50 Countering the U.S. Opioid Epidemic. The Action Collaborative was formed in 2018 as a public-

1 private partnership to foster greater coordination and collective action across the health system and
2 beyond in addressing the opioid addiction crisis.^{xlii} The Action Collaborative uses a systems
3 approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate,
4 and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes
5 for individuals, families, and communities affected by the opioid crisis.

6
7 The Action Collaborative conducts its work around four core priority areas: Health Professional
8 Education and Training; Pain Management Guidelines and Evidence Standards; Prevention,
9 Treatment, and Recovery Services; and Research, Data, and Metrics Needs. The Action
10 Collaborative produces discussion papers to advance the field and accelerate action where the
11 evidence dictates; conducts outreach; and leads convenings, webinars, and other special events to
12 accelerate the translation of the most promising opportunities to reverse the opioid crisis.

13
14 **3. Strengthen the health system through improved collaboration between medicine and**
15 **public health.**

16
17 A. Strengthen physician and trainee knowledge of public health and social determinants of health.

18
19 The AMA makes education on public health and health equity available on the AMA Ed HubTM to
20 empower individuals and organizations, in health care and beyond, in advancing health equity and
21 the betterment of public health. The Ed Hub contains curated education from trusted sources on a
22 wide range of public health issues. The AMA's Center for Health Equity has developed educational
23 content to empower individuals and organizations, in health care and beyond, in advancing racial
24 justice and equity.^{xliii}

25
26 The AMA is transforming medical education across the continuum and collaborating with
27 undergraduate and graduate medical education institutions to create a system that trains physicians
28 to meet the needs of today's patients and anticipate future changes. This includes working with
29 schools to implement instruction in health systems science (HSS), the third pillar of medical
30 education, along with the basic and clinical sciences. The HSS curriculum includes issues related to
31 how social determinants of health affect the entire population and the improvement strategies at the
32 population health level to address gaps in care such as the organized assessment, monitoring or
33 measurement of key health metrics necessary to improve health outcomes for a group of
34 individuals.^{xliv}

35
36 B. Maintain AMA relationships with national public health organizations.

37
38 The Association of State and Territorial Health Officials (ASTHO), National Association of City
39 and County Health Officials (NACCHO), and the American Public Health Association (APHA) are
40 all designated liaisons to the Council on Science and Public Health. AMA staff are engaged in
41 regular discussions to understand their perspectives and opportunities for collaboration.

42
43 C. Collaborate with leading health care organizations to strengthen the interface between public
44 health and health care.

45
46 A new health care industry consortium has agreed to work together, in partnership with public
47 health, to focus on strengthening the interface between public health and health care. The
48 consortium includes some of the most prominent and influential organizations from the health care
49 sector. Core membership organizations will include: AHIP (formerly America's Health Insurance
50 Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA),
51 American Medical Association (AMA), and Kaiser Permanente (KP).

1
2 The consortium, which will be governed by senior leaders from each of the core member
3 organizations and staffed by independent policy analysts and other experts, will focus on areas
4 where there is significant opportunity for consensus building and where health care partners are
5 uniquely positioned to play a significant role in advancing the work. The consortium has agreed to
6 focus its initial work on four specific priorities and will work over the coming months to further
7 define concrete, pragmatic, and tangible actions to advance these priorities.

8
9 Priority Actions Areas will include.

- 10 1) Formalizing agreements and supporting coordinated efforts between public health and
11 health care with clear communication of goals, roles, responsibilities, tasks, and
12 deliverables.
- 13 2) Evolving and supporting robust scalable emergency preparedness programs.
- 14 3) Establishing national standards, processes and use cases for stratifying public health and
15 health care data by sociodemographic variables to identify disproportionate health impacts
16 and outcomes at the community level.
- 17 4) Modernizing and integrating an infectious disease surveillance system that unifies data
18 across sectors, agencies, and data systems, including novel data sources (e.g., social media)
19 and advanced analysis methods.

20 21 **4. Combat the spread of misinformation and disinformation.**

22
23 At the 2022 Annual Meeting of the HOD, the Board’s report on, “Addressing Public Health
24 Disinformation Disseminated by Health Professionals” was adopted. AMA Policy, D-440.914,
25 “Addressing Public Health Disinformation Disseminated by Health Professionals,”
26 outlines a comprehensive strategy to address health-related disinformation disseminated by health
27 professionals. Aspects most relevant to public health include the following:

28
29 A. Maintaining AMA as a trusted source of evidence-based information for physicians and
30 patients.

31
32 While the public’s trust in many institutions has waned during the COVID-19 pandemic, people
33 generally still trust their doctors. In his November 12, 2021, address to the AMA House of
34 Delegates, AMA CEO/EVP James Madara, MD, noted that, “[t]he AMA exists to benefit the
35 public, but we do so in a very particular way—by being the physicians’ powerful ally in patient
36 care. We serve the public by serving those who care for the public. Supporting physicians and
37 improving our nation’s health has been our focus since 1847.”^{xlv}

38
39 B. Combat public health mis- and disinformation that undermines public health initiatives.

40
41 The AMA has continued to issue press statements, noting the harm of mis- and disinformation and
42 has urged the CEOs of six leading social media and e-commerce companies to assist the effort by
43 combatting misinformation and disinformation on their platforms. The AMA has remained a source
44 of trusted information providing physicians with up-to-date information on public health issues.

45
46 C. Collaborate with stakeholders to ensure all patients have equitable access to and confidence in
47 accurate, understandable, and relevant information necessary to make health decisions.

48
49 The AMA has engaged in several collaborates to address mis- and disinformation. The recently
50 announced Coalition for Trust in Health and Science brings together reputable associations
51 representing academics, researchers, scientists, doctors, nurses, pharmacists, drug and insurance

1 companies, consumer advocates, and public health professionals.^{xlvi} The coalition will support
2 efforts to advance people’s scientific and health literacy, earn public trust and improve health
3 outcomes and health equity as well as to correct misinformation and counter disinformation that
4 threatens health and well-being. The AMA has also been engaged with the work led by NAM,
5 WHO, and the Council of Medical Specialty Societies on a project focused on identifying credible
6 sources of health information in social media.^{xlvii}

7
8 CONCLUSION

9
10 The strategy outlined provides an overview of the work the AMA is doing in public health and
11 indicates our current priorities. While much of this work resides in Health, Science and Ethics,
12 other business units lead portions of this work including Improving Health Outcomes, the Center
13 for Health Equity and Medical Education. Advocacy, Communications, the Ed Hub team,
14 Marketing and Member Experience are also vital to advancing these efforts. Many of the public
15 health crises being addressed by the AMA are not going to be solved by our organization alone.
16 Collaboration is going to be critical, and the AMA has taken steps to engage other organizations in
17 this work where it makes sense. While there are many areas where the AMA is asked to engage,
18 the areas outlined above represent our focus in advancing the AMA’s mission towards the
19 betterment of public health.

20
21 RECOMMENDATION

22
23 The Board of Trustees recommends that the following be adopted in lieu of Resolution 605-A-22
24 and the remainder of the report be filed.

- 25
26 1. Our AMA will distribute evidence-based information on the relationship between climate
27 change and human health through existing platforms and communications channels,
28 identify advocacy and leadership opportunities to elevate the voices of physicians on the
29 public health crisis of climate change, and centralize our AMA’s efforts towards
30 environmental justice and an equitable transition to a net-zero carbon society by 2050.
31 (New HOD Policy)

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REPORT 04 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
School Resource Officer Violence De-escalation Training and Certification
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 416-A-22, referred for study by the House of Delegates, asked that our American Medical Association study the efficacy of School Resource Officer violence de-escalation training and certification.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “school resource officer”, “school-based law enforcement,” and “school resource officers AND training”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped full-time law enforcement officer, trained in school-based law enforcement and crisis response, assigned to work in the school using community-oriented policing concepts. Recently, the number of SROs has skyrocketed. Opponents to SROs argue that they damage school climate, criminalize relatively trivial student behavior, and fuel the school-to-prison pipeline. While proponents argue that SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models, and law-related educators for students.

SRO officers may receive training in, among other things, mental health awareness, adolescent development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis intervention, cultural competence, and school-specific topics. However, within school systems, trainings vary in content and delivery. One intervention, which has limited support in the research literature, is the use of de-escalation techniques and training for educational entities to mitigate the impact of peer aggression and promote the safety of the school environment.

CONCLUSION. This report recognizes that SROs are part of the school staff at large and should not be considered a separate entity from school counselors, social workers, school psychologists, nurses, and schoolteachers. The recommendations support the need for their roles to be defined within the team structure of the school and also supports the use of community-based policing practices to ensure that the community plays a role in prioritizing and addressing public safety. The current evidence is inconclusive on the effectiveness of de-escalation training for SROs. However, research shows that multi-faceted interventions are more likely to be effective, especially in school settings. Further, the recommendations support establishing an agreed-upon operating protocol or memorandum of understanding (MOU) that includes provisions addressing daily interactions between students and school personnel with SROs.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 04-A-23

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

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 Resolution 416-A-22, referred for study by the House of Delegates, asked that our American
2 Medical Association study the efficacy of School Resource Officer violence de-escalation training
3 and certification.

4 5 BACKGROUND

6
7 A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped
8 full-time law enforcement officer, trained in school-based law enforcement and crisis response,
9 assigned to work in the school using community-oriented policing concepts.¹ Recently, the number
10 of SROs has skyrocketed. An estimated 14,000 to 20,000 SROs now work in schools, and the
11 number continues to grow.² Opponents argue that SROs damage school climate, criminalize
12 relatively trivial student behavior, and fuel the school-to-prison pipeline.³ Proponents argue that
13 SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models,
14 and law-related educators for students. One report concluded that for every dollar invested in the
15 program, a minimum of \$11.13 of social and economic value was created.⁴

16
17 SRO officers may receive training in, among other things, mental health awareness, adolescent
18 development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis
19 intervention, cultural competence, and school-specific topics.⁵ However, within school systems,
20 trainings vary in content and delivery. For example, some training courses include information on
21 evaluation of the de-escalation and crisis response (e.g., support for staff and students after an
22 incident). Further, some training may be a stand-alone curriculum, whereas others may include de-
23 escalation as a topic within other training topics (e.g., classroom management, discipline policy,
24 academic planning).

25
26 One main intervention, which has limited support in the research literature, is the use of de-
27 escalation techniques and trainings for educational entities to mitigate the impact of peer
28 aggression and promote the safety of the school environment.⁶ Across various professional fields,
29 such as public health and education, de-escalation training involves learning strategies for the
30 prevention and the management of aggression and violence. De-escalation may include training in
31 early intervention practices, communication methods (i.e., verbal and non-verbal styles),
32 appropriate responses in potentially violent situations, and the correct use of physical intervention
33 techniques (e.g., restraint techniques, protection). The training is intended to reduce conflict,
34 aggression, and harm. In an educational setting, de-escalation can be defined as a range of
35 interconnected interventions that include verbal and non-verbal communication, self-regulation
36 assessment, and actions taken while maintaining the safety of the those in the school.

1 METHODS

2
3 English language articles were selected from searches of PubMed and Google Scholar using the
4 search terms “school resource officer”, “school-based law enforcement,” and “school resource
5 officers AND training”. Additional articles were identified by manual review of the reference lists
6 of pertinent publications. Websites managed by government agencies; applicable organizations
7 were also reviewed for relevant information.

8 9 DISCUSSION

10 11 *What are SROs?*

12
13 The only definition of SRO in current federal law appears under the authorizing legislation for the
14 Office of Community Oriented Policing Services (COPS Office), which is a component of the U.S.
15 Department of Justice responsible for advancing the practice of community policing primarily
16 through grant resources. This statute defines an SRO as “a career law enforcement officer, with
17 sworn authority, deployed in community-oriented policing, and assigned by the employing police
18 department or agency to work in collaboration with schools and community-based organizations.”⁷
19 Although specific responsibilities and functions of SROs vary from place to place, the “triad”
20 concept of school-based policing divides SRO responsibilities into three main areas of: teacher,
21 informal counselor, and law enforcement officer.⁸

22 23 *History of SROs*

24
25 Since the 1900s, U.S. public schools have employed a growing number of SROs. In 1975, only 1
26 percent of schools reported having police officers on site, but by 2018, approximately 58 percent of
27 schools had at least one sworn law enforcement official present during the school week.⁹ In
28 response to school shootings in the 1990s, federal and state legislation spurred this rapid
29 proliferation of SROs.

30
31 The first use of SROs in schools is reported to have been in Flint, Michigan, in the early 1950s.¹⁰
32 While police have had a presence in schools since then, it has only been over the past 20 years that
33 the practice of assigning police officers to schools on a full-time basis has become more
34 widespread. The number of SROs expanded significantly beginning in the 1990s due to legislative
35 initiatives in response to concerns over a series of school shootings including the Columbine
36 tragedy. The 1994 reauthorization of the Elementary and Secondary Education Act (ESEA)
37 included provisions that established school safety as a core focus for the U.S. Department of
38 Education (U.S. DOE).¹¹ It also included the Safe and Drug-Free Schools and Communities Act,
39 which authorized federal support for police in schools via a grant program wherein local education
40 agencies could use funds to hire and train SROs.^{7,12} Between 1994 and 2009, up to 40 percent of
41 federal funding for this act could be used to hire and train school police and support other security
42 measures.¹³ Overall, since 1998, the federal government has invested over \$1 billion to explicitly
43 increase police presence in schools, and over \$14 billion to advance community policing, which
44 can include SROs.^{10,14}

45
46 In recent years, federal funding and support for SROs has increased following tragic school
47 shootings. Despite their concerns about the unintended negative consequences of SROs, the Obama
48 Administration renewed funding to increase the number of SROs across the country after the 2012
49 shooting at Sandy Hook Elementary School in Newtown, Connecticut.¹⁵ Following the 2018

1 shooting at Marjory Stoneman Douglas High School in Parkland, Florida, the Trump
2 Administration prioritized SRO positions in selecting COPS grants recipients.¹⁶

3 *Federal Policy on SROs*

4
5 Despite their growth and the substantial federal funding, there is very little federal policy explicitly
6 defining the role of SROs. The absence of SROs from federal educational policy is in part due to
7 the Obama administration's concerns over unintended negative consequences of police presence in
8 schools.¹⁷ The vagueness of federal law has led to large variation in the role, expectations, and
9 accountability of police in schools. Moreover, federal-level data collection on SROs is also
10 severely lacking. SROs are not required to register with any national database, police departments
11 are not required to report how many of their officers work as SROs, and school systems are not
12 required to report how many SROs they employ.¹ Since 2013-2014, the U.S. Department of
13 Education has collected survey data every other year that details the number of student referrals
14 and arrests made by school police (including SROs) in public schools, and which students are most
15 affected.¹⁸ The data also include the number of counselors, social workers, school psychologists,
16 and nurses that are in a school compared to the number of SROs.¹⁹ Given this overall lack of
17 descriptive data there is little information on the roles of SROs nationally or how, if at all, SROs
18 are trained. By failing to collect these data, it is difficult to monitor and evaluate the work of SROs
19 and their impact.

20
21 *State Policy on SROs*

22
23 Federal policy and accompanied funding initiatives fueled the growth of SROs programs which are
24 now operated in all 50 states.^{14,19} Yet, the lack of federal law on SROs has led to a patchwork of
25 state policy. Out of all 50 states and Washington D.C., only 26 jurisdictions specifically define
26 SRO in state statutes or regulations.¹⁹ These state-level definitions do not specify the role of SROs
27 in schools. Most states encourage schools or districts to enter into a Memorandum of
28 Understanding (MOU) with local law enforcement if they provide an SRO. For example,
29 Connecticut, Massachusetts, Ohio, and South Carolina require MOUs to outline the role of the
30 SRO.²⁰

31
32 The National Association of School Resource Officers (NASRO) suggests SROs receive at least 40
33 hours of specialized training in school policing prior to being assigned.²⁰ NASRO's Basic SRO
34 training is set up as a 5- day, 40-hour block of instruction and outlines evidence-based best
35 practices for SRO programs.²⁰ This training covers the following topics: constitutional and state
36 law, armed response, crime prevention and mitigation, interview and interrogation techniques,
37 investigations, crime prevention through environmental school design, patrol operations, advocacy
38 within the juvenile justice system, and mandatory reporting.²⁰ Twenty-eight state statutes or
39 regulations include language regarding training requirements for SROs, but these also vary widely
40 and laws in only two states specify a required length of training.²¹ In several states, the training is
41 simply what is required of traditional law enforcement, including firearm or active shooter
42 training.²² Instruction regarding how to effectively interact with youth averages around four to six
43 hours across all states.²² Training in sixteen states includes what is required of traditional law
44 enforcement in addition to school-specific training. Few states explicitly require training in de-
45 escalation or conflict resolution, mental health, youth development, or school climate.²² Only
46 Maryland and Utah explicitly include provisions for training in "implicit bias and disability and
47 diversity awareness with specific attention to racial and ethnic disparities" and "cultural
48 awareness," respectively.²² Therefore, across states there is wide variation in expectations
49 regarding SRO training. Additionally, training is primarily standard police training, with little
50 education on working in school settings and with youth.

51

1 Illinois is an example of this heterogeneity of approach. Illinois state law requires SROs to
2 complete training within one year of assignment.²³ This training must cover juvenile developmental
3 issues, youth mental health, how to prevent child abuse and exploitation, and various educational
4 administrative issues. Illinois does not explicitly require implicit bias, disability training, or de-
5 escalation training.

6 *School District Policy on SROs*

8
9 SRO training and duties vary across school districts. In general, SROs must enforce school rules
10 and the law, as well as be visible authority figures in schools. They can also participate in
11 mentorship programs, provide students with training on safety and violence, and promote a positive
12 school environment.²⁴ SROs usually patrol school halls to discourage students from misbehaving,
13 and when a student is caught breaking a school rule or the law, SROs step in to investigate and
14 assist with student discipline. Certain school districts require SROs to follow zero tolerance policies
15 when students are caught with drugs, meaning the SRO has zero discretion in how to respond.
16 Other school districts allow SROs to use discretion to decide a disciplinary course of action.²²

17 *Benefits of School Resource Officers*

18
19
20 School resource officers can provide a variety of benefits not only to schools, but to individual
21 students and local police departments. These benefits include promoting school safety, addressing
22 the root causes of student misbehavior, and decreasing juvenile delinquency petitions where SROs
23 are properly utilized.²⁵ Further, SROs can improve relationships between students and law
24 enforcement, serve as protectors for victimized students, and reduce the burden on local law
25 enforcement. Although there has been limited research, it is hypothesized that SROs can promote
26 safety in schools by deterring criminal activity at schools, specifically more serious crimes
27 including possession of a weapon and assault.²⁶ SROs can also aid in reducing the amount of
28 fighting and bullying on campus through hallway patrols, which can allow SROs to intervene
29 rather quickly when there is a fight.²⁶ Students may be less likely to break the rules or pick a fight
30 when SROs are patrolling school grounds because of the increased probability of being caught.

31
32 Some districts have found that SROs can use their positions to identify the root cause of school
33 misbehavior and help students address it. When SROs are properly utilized, they can potentially
34 help offset the school-to-prison pipeline. For example, SROs in Franklin County, Virginia, often
35 impose alternative methods of punishment to delinquency petitions, such as community service,
36 school service, or mediation.²⁶ Once a student has completed his act of service, they are often
37 encouraged to participate in afterschool extracurricular activities in order to create structure and
38 prevent a second offense. In Franklin County, SROs only send a request for a delinquency petition
39 to the state's attorney after all other avenues have been explored. A study of schools in this county
40 that utilize this approach found a 64 percent decrease in potential delinquency petitions.²⁷

41
42 Research also reveals that SRO programs can improve relationships and build trust between
43 students and law enforcement. A 2016 study that surveyed students from various schools in one
44 southeastern U.S. school district analyzed how students' attitudes towards SROs change with
45 increased interaction.²⁶ Overall, more student-SRO interactions were positively correlated with
46 favorable feelings towards SROs. Other research shows that this improved trust can later help
47 uncover previously unknown issues of abuse and neglect, because victims may feel more
48 comfortable reporting the issue to law enforcement.²⁷ Additionally, SROs can sometimes serve as
49 protectors for students, which can make students feel more comfortable asking for help. This is
50 especially true for students who are victims of various crimes, abuse, and bullying, and who may
51 feel safer attending school knowing an SRO is available to protect them.²⁷ SROs have the unique

1 ability to immediately intervene if a juvenile offender violates any court ordered condition, thereby
 2 increasing a victim's sense of safety at school. Finally, SROs can reduce the burden on law
 3 enforcement outside of the school. When officers are stationed at schools, the school often no
 4 longer needs to call 911 when a dangerous situation arises because it simply informs the SRO. This
 5 gives the school a quick response time while allowing patrol officers to focus on issues outside of
 6 schools. Overall, some of the benefits of SROs include:

- 8 • Increasing feelings of safety among students, teachers, and administrators,
- 9 • Deterring aggressive behavior, and empowering staff to maintain order and address
 10 behavioral issues in a timely fashion,
- 11 • Diminishing classroom time spent on discipline and behavioral disruptions,
- 12 • Improving school safety and reducing school-based crime,
- 13 • Increasing the likelihood that students report witnessing a crime, and help reduce
 14 community-wide criminality, and
- 15 • Improving relationships between law enforcement and youth.

17 *Impacts on Safety for Marginalized Youth*

18
 19 In the triad model concept advanced by NASRO, in addition to their law enforcement role, SROs
 20 will act as another mentor, educator, or counselor. However, this assumption ignores the fact that
 21 Black youth, Latinx youth, immigrant youth, indigenous youth, and youth living in poverty often
 22 come to school with harmful experiences with police that may perpetuate racial inequalities in
 23 educational, health, and social outcomes.²⁸ By placing SROs in schools, these traumatic issues can
 24 be exacerbated. SROs are more likely to reproduce broader patterns of police targeting and
 25 criminalizing Black, Indigenous, Latinx, and students of color.²⁹

26
 27 Further, SROs are disproportionately placed in schools serving predominantly students of color,
 28 as opposed to schools serving predominantly white populations.³⁰ Among middle and high
 29 schools where more than 75 percent of students were Black, 54.1 percent had at least one SRO or
 30 security officer on campus.^{31,32} By comparison, among middle and high schools where over 75
 31 percent of students were white, only 32 percent had SROs.^{32,33}

33 *SROs Are Associated with Higher Rates of Exclusionary Discipline and Criminalization*

34
 35 Additionally, numerous studies show that the presence of SROs in schools is associated with higher
 36 rates of exclusionary discipline (suspensions and expulsions) which increases the risk of students
 37 being pushed into the “school to prison pipeline.”³³ Students of color across the nation are
 38 disproportionately subject to these exclusionary discipline practices.³⁴ For example, in Connecticut,
 39 suspension and expulsion rates for Black and Latino male students are two to three times that of
 40 their white counterparts.³⁵ The suspension rate for Black female students is around five times that
 41 of their white counterparts.³⁶

42
 43 Additionally, SROs create the potential to escalate school disciplinary issues, even minor ones, into
 44 arrestable offenses.³⁶ In one survey of SROs, 77 percent reported that they had arrested a student to
 45 calm them down and 55 percent reported arresting students for minor offenses because the teacher
 46 wanted the student to be arrested.³⁷ The majority of school-based arrests are for non-violent
 47 offenses, such as disruptive behavior.³⁹ Further, studies show that the presence of an SRO increases
 48 the number of arrests for “disorderly conduct” – an often ambiguous, and subjective
 49 characterization of behavior.³⁸ Overall, research suggests that SROs’ potential to escalate conflicts
 50 puts students at risk.³⁹ For example, schools that employed police had an arrest rate 3.5 times that

1 of schools without police.⁴⁰ As with exclusionary discipline, students of color are
2 disproportionately subject to school arrests.⁴²

3 This pipeline extends further for undocumented students, as contact with SROs can put them at risk
4 of detention and deportation.⁴¹ This risk is heightened in communities where local law enforcement
5 is contracted with Immigration and Customs Enforcement under 287(g) agreements – which allows
6 the Department of Homeland Security to deputize selected state and local law enforcement officers
7 to enforce federal immigration law.⁴² Since 2013, COPS Grants have required recipients to sign a
8 287(g) agreement in order to receive funds. There are several documented cases of SROs putting
9 immigrant students at risk of “school-to-deportation pipelines.”^{43,44}

10 *Interference with Education*

11 The presence of SROs and exclusionary discipline negatively impacts students’ academic
12 achievement and can accelerate future misbehavior, truancy, and drop-out rates.⁴⁷ Students who
13 have contact with the criminal legal system through arrests and searches experience worse
14 schooling outcomes than those who do not. Arresting students doubles their risk of dropping out.⁴⁵
15 The consequences of a school arrest extend far beyond a youths’ public-school outcomes and
16 include the loss of access to higher education and funding, job eligibility, access to public housing,
17 and increasing both the likelihood and consequence of future law enforcement contact.⁴⁶ Further,
18 trauma and anxiety symptoms can increase with the frequency of police contact, regardless of
19 where that contact occurs. For many students of color, police presence in schools can cause re-
20 traumatization given their negative experiences with law enforcement in their communities.⁵⁰

21 The presence of SROs can shift the focus from learning and supporting students to over-
22 disciplining and criminalizing them. Regular police contact, even if this contact is in passing,
23 affects how Black and Latinx youth perceive themselves, their school, and law enforcement.⁴⁷
24 Students of color have reported feeling the police are there to protect the school from them.⁴¹
25 Further, other research shows that the presence of SROs reduced students’ feelings of school
26 connectedness – the belief that adults and peers in the school care about them as humans.^{26,48}
27 School connectedness is an important protective factor – young people who feel connected to their
28 school are less likely to engage in behaviors that are harmful to themselves or others and are more
29 likely to have better academic achievement, attendance, and persistence.⁵⁰ Research also
30 demonstrates that racial and ethnic disparities in discipline are not the consequence of differences
31 in rates or types of misbehavior by students of color and white students but rather racial and
32 cultural biases.⁴⁴

33 Lastly, the focus on SROs has also diverted attention and funds from other areas of education that
34 could support students. Between 1999 and 2015, the percentage of students who reported security
35 guards or assigned police officers in their schools increased from 54 percent to 70 percent while the
36 number of school counselors increased by only 5 percent, after adjusting for the growth in student
37 enrollment.⁴² There are also more sworn law enforcement officers than social workers in schools
38 across the U.S., with many states employing two-to-three times as many police officers in than
39 social workers in schools.⁴⁹ Over 4,800 schools reported employing more school police and
40 security than school-based mental health providers.⁵³ Across the country 1.7 million students are in
41 schools with police but no counselors; 3 million are in schools with police but no nurses; 6 million
42 students are in schools with police but no school psychologists; 10 million students are in schools
43 with police but no social workers.⁴² Compared to white students, Latinx, Asian, and Black students
44 are more likely to attend schools where the districts chose SROs over counselors.⁵⁰

45 *Impact of SROs on School Shootings*

1
2 There is limited evidence supporting the role of SROs in preventing school shootings.⁵¹ Research
3 on averted school shootings – incidents planned by students and then prevented – suggests that the
4 key is having trusted adults whom other students can inform.⁵² One study found that students are
5 much more likely to report a planned shooting to school staff members; they rarely report this to a
6 member of law enforcement.⁵⁶ There is also limited evidence on whether SROs can stop an active
7 shooter or lower deaths or injuries when a school shooting happens. A recent study found that
8 among all schools that experienced a school shooting between 1999 and 2018, the number of
9 injuries and deaths was about 2.5 times higher in schools that had an SRO.⁵³ However, in at least
10 one instance a school shooter deliberately selected an elementary school with no security personnel
11 instead of the middle school they attended because their middle school had an armed security
12 officer.⁵⁴ Further, one study found in one-quarter of the studied cases with an active shooter, the
13 officer or SRO was able to make it to the scene of the attack within one minute. In three of the
14 attacks (7 percent), it took between one and five minutes for the officer to respond, and for two
15 attacks (5 percent), it took between five and ten minutes.⁵⁵ In sum, further research is needed to
16 understand the role SRO's have in deterring school shooters.

17 18 *Maximizing the Benefits of SRO Programs*

19
20 Although there has been interest in encouraging the expansion of SRO programs to promote school
21 safety, some are concerned about the negative effects SROs could have on the school environment.
22 While research on the efficacy of particular program models or characteristics is limited, the COPS
23 Office, has identified several elements of a successful SRO program.⁵⁶ First, the COPS guide
24 suggests that all schools should develop a comprehensive school safety plan based on their school
25 safety goals and a thorough analysis of the problem(s) the school is facing before determining if it
26 is necessary to employ an SRO.⁵⁹ In some instances, school safety plans might not require the
27 deployment of an SRO. However, if after composing a school safety plan the school decides to use
28 an SRO, there should be clear goals for the program. SROs should engage in problem-solving
29 policing activities that directly relate to school safety goals and address identified needs, and data
30 should be collected to determine whether the program is achieving its goals.

31
32 Second, the COPS guide suggests that schools and the law enforcement agencies that SROs work
33 for should be aware of any pitfalls before agreeing to establish an SRO program.⁵⁹ There may be
34 philosophical differences between school administrators and law enforcement agencies about the
35 role of the SRO. Law enforcement agencies focus on public safety while schools focus on
36 educating students. Establishing an agreed-upon operating protocol or MOU is considered a critical
37 element of an effective school-police partnership. The MOU should clearly state the roles and
38 responsibilities of SROs involved in the program.⁵⁹ However, most schools employing SROs do not
39 enter into a MOU. Further, MOUs are not publicly available on school websites. This means that
40 key stakeholders such as students and families lack easy access to information regarding their
41 rights in relation to interacting with police in schools.⁶⁹

42
43 Third, the COPS guide suggests that selecting officers who are likely to succeed in a school
44 environment—such as officers who can effectively work with students, parents, and school
45 administrators; have an understanding of child development and psychology; and have public
46 speaking and teaching skills—and properly training those officers are important components of a
47 successful SRO program.⁵⁹ While it is possible to recruit officers with some of the skills necessary
48 to be effective SROs, it is also important to provide training so officers can hone skills they already
49 have or develop new skills that can make them more effective. The Police Foundation, for instance,
50 recommends that training for SROs focus on the following:

- 1 • child and adolescent development, with an emphasis on the effect of trauma on student
- 2 behavior, health, and learning,
- 3 • subconscious (or implicit) bias that can disproportionately affect youth of color and youth
- 4 with disabilities or mental health issues,
- 5 • crisis intervention for youth,
- 6 • alternatives to detention and incarceration, such as peer courts, restorative justice, etc., and
- 7 • legal issues like special protections for students with disabilities.⁵⁷

8
9 Further, one study that surveyed educators, students, officers, and community members suggests
10 that successful SRO programs can do the following:

- 11 • Increase feelings of safety among students, teachers, and administrators,
- 12 • Deter aggressive behavior, and empower staff to maintain order and address behavioral
- 13 issues in a timely fashion,
- 14 • Diminish classroom time spent on discipline and behavioral disruptions,
- 15 • Improve school safety and reduce school-based crime,
- 16 • Increase the likelihood that students report witnessing a crime, and help reduce
- 17 community-wide criminality, and
- 18 • Improve relationships between law enforcement and youth.⁵⁸

19 20 EXISTING AMA POLICY

21
22 AMA policy H-60.902, “School Resource Officer Qualifications and Training” encourages an
23 evaluation of existing national standards to have qualifications through training and certification
24 that includes child psychology and development, restorative justice, conflict resolution, crime
25 awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and
26 institutional safety and others deemed necessary for school resource officers. It also encourages the
27 development of policies that foster the best environment for learning through protecting the health
28 and safety of those in school, including students, teachers, staff, and visitors.

29 30 CONCLUSIONS

31
32 Police stationed within K-12 schools, known as SROs, are a common feature of American schools.
33 According to federal data, about half of schools had an SRO on school grounds at least once a
34 week during the 2017-2018 school year.⁵⁹ In the same year, a national survey found that 80 percent
35 of parents supported having police officers in schools, and some states, like Maryland, passed new
36 laws mandating adequate law enforcement at all schools as a result of school shootings.^{60,61}
37 However, since George Floyd’s death in 2020, the U.S. has experienced an intensified debate about
38 the proper role of police in communities, including schools. As a result, school districts, including
39 Chicago and Los Angeles, have significantly cut their budgets for school policing.⁶²

40
41 Opponents of SROs often cite specific incidents of police violence against Black students in
42 schools and link SROs to the broader concept of a school-to-prison pipeline, in which students’
43 early experiences with school discipline and/or police in schools may directly or indirectly
44 influence their lifetime involvement with the criminal justice system.⁶² Critics of SROs fear that
45 having a police officer within a school makes it easier for a student to be formally arrested or
46 referred to juvenile justice for minor acts of misconduct that would otherwise be handled through
47 school discipline.⁶³ This criminalization of school misconduct disproportionately impacts students of
48 color, as evidenced in the existing racial disparities in arrest and incarceration.⁴⁰

49

1 Proponents state that school districts often view SROs as the first line of defense against school
2 shootings and other acts of school violence. SROs also aim to act as a specialized form of
3 community policing, a model of policing designed to assign officers to permanent beats, involve
4 students in decision-making, and problem-solve using non-criminal justice techniques such as
5 mentoring and informal sanctions.⁶⁴ Consistent with this logic, research has shown that SROs may
6 improve student attitudes toward the police and improve student and staff perceptions of school
7 safety.²⁶

8
9 The current evidence is inconclusive on the effectiveness of de-escalation training for SROs.
10 However, multi-faceted interventions are more likely to be effective, especially in school settings.
11 Examples of evidence-based best practices include training on restorative justice, transformative
12 justice, and trauma-sensitive or trauma-informed schooling.⁶⁵ At the center of each of these
13 approaches is the development of: healthy relationships; processes that support the healing of harm
14 and transformation of conflict; and just and equitable learning environments that confront
15 oppressive structures and systems.⁶⁹

16
17 Further, establishing an agreed-upon operating protocol or MOU is considered a critical element of
18 an effective school-police partnership. The MOU should include provisions addressing daily
19 interactions between students and school personnel with school resource officers.⁶⁶ MOUs are
20 widely considered important tools to clarify how SROs should operate in an educational
21 environment.⁶⁷ However, most school districts employing SROs do not have a MOU in place.
22 Research shows that an upfront MOU agreement can result in fewer court referrals, fewer violent
23 offenses, and higher graduation rates.⁶⁸

24
25 It is also important to recognize that SROs are part of the school staff at large and shouldn't be
26 considered a separate entity from school counselors, social workers, school psychologists, nurses,
27 and schoolteachers. Their roles should therefore be defined within the team structure of the school.
28 Finally, community-based policing practices ensure that the community plays a role in prioritizing
29 and addressing public safety problems.⁶⁹ SRO programs employing these practices can be used to
30 accomplish two interrelated goals of developing solutions to problems through collaborative
31 problem solving and improving public trust.

32 33 RECOMMENDATIONS

34
35 The Council on Science and Public Health recommends that the following be adopted, and the
36 remainder of the report be filed.

- 37
38 1. That our AMA amend Policy H-60.902, "School Resource Officer Qualifications and
39 Training" as follows:

- 40 1. Our AMA encourages: (1) an evaluation of existing national standards (and
41 legislation, if necessary) to have qualifications by virtue of training and
42 certification that includes child and adolescent psychology and development,
43 trauma-informed care, restorative justice, peer mediation, conflict resolution, crime
44 awareness, implicit/explicit biases, how to work with children with disabilities and
45 special needs, diversity inclusion, cultural humility competence of the distinct
46 cultural groups represented at schools, de-escalation training, and individual and
47 institutional safety and others deemed necessary for school resource officers; and
48 (2) the development of policies that foster the best environment for learning
49 through protecting the health and safety of those in school, including students,
50 teachers, staff and visitors. (Modify HOD Policy)

- 1 2. That our AMA encourage: (1) school districts initiating SROs develop and those with
2 existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly
3 outlines processes for officer selection and assessment, defines roles and responsibilities of
4 SROs and their scope relative to school personnel, identifies data to be collected, and
5 establishes a mechanism for program evaluation and oversight; (2) SROs to have access to
6 local public health resources; (3) schools with SRO programs to collect and report data to
7 help evaluate the impact of SROs in schools; and (4) federal and state grant programs
8 which provide funding for SRO programs, require collection and reporting of data to
9 inform policymaking on these programs. (New HOD Policy)
10
11 3. That our AMA acknowledges: (1) SROs are part of the school staff at large and their
12 responsibilities should be defined within the team; and (2) community-based policing
13 practices are essential for a successful SRO program. (New HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 05 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Increasing Public Umbilical Cord Blood Donation in Transplant Centers
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. The first Resolve of Resolution 001-A-22, “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers,” which was referred by the House of Delegates, asked that our American Medical Association (AMA) “encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation.”

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “umbilical cord blood donation,” “public umbilical cord blood donation,” and “umbilical cord blood AND transplantation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations will also be reviewed for relevant information.

DISCUSSION. Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the placenta. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with unrelated donor bone marrow. The predominant disadvantage of umbilical cord blood use is that there is often a low yield of stem cells acquired per unit. In general, UCB can be donated to a private or public bank. A private umbilical cord blood bank is a for-profit company that allows storage of umbilical cord blood for personal use. In contrast, public umbilical cord blood banks offer gratuitous cord blood banking for individuals who meet the donation requirements. This report examines the benefits and limitations of public versus private umbilical cord blood banking.

CONCLUSION. Cord blood banking has been developed to the point that around 800,000 units are being stored in public banks and over 4 million units in private banks worldwide. Although UCB units are not the answer for every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients every year who have no alternative treatment modality. Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One notable barrier is that public UCB banks are required to process, and store collected units within 48 hours of collection. This limits the collection sites to proximally located hospitals. This provides a barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This, coupled with the lack of funding for efforts to improve recruitment and education of expectant parents, leads to insufficient UCB donations and availability for transplant. The recommendations aim to address these barriers to improve and expand the current UCB donations and banking. This report also studies the financial costs of setting up public UCB banks and the long-term financial outlook for maintaining public UCB banks.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 05-A-23

Subject: Increasing Public Umbilical Cord Blood Donation in Transplant Centers

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2

3 The first Resolve of Resolution 001-A-22, “Increasing Public Umbilical Cord Blood-Donations in
4 Transplant Centers,” which was referred by the House of Delegates, asked that our American
5 Medical Association (AMA) “encourage all hospitals with obstetrics programs to make available to
6 patients and reduce barriers to public (altruistic) umbilical cord blood donation.”

7

8 BACKGROUND

9

10 Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the
11 placenta. UCB is now known to contain hematopoietic stem cells that have potential life-saving
12 benefits. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several
13 distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater
14 degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence
15 of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with
16 unrelated donor bone marrow.¹ The predominant disadvantage of umbilical cord blood use is that
17 there is often a low yield of stem cells acquired per unit. Only 8–12 percent of umbilical cord blood
18 units have sufficient cell volume for transplant to a person weighing 80 kg (176 lb).² In general, a
19 private UCB bank is a for-profit company that allows storage of UCB for personal use. In contrast,
20 public UCB banks offer gratuitous cord blood banking for individuals who meet the donation
21 requirements. The benefits and limitations of public versus private UCB banking should be
22 reviewed with the patient individually because they serve different purposes.

23

24 METHODS

25

26 English language articles were selected from searches of PubMed and Google Scholar using the
27 search terms “umbilical cord blood donation,” “public umbilical cord blood donation,” and
28 “umbilical cord blood AND transplantation.” Additional articles were identified by manual review
29 of the reference lists of pertinent publications. Web sites managed by government agencies and
30 applicable organizations were also reviewed for relevant information.

31

32 DISCUSSION

33

34 *Umbilical Cord Blood*

35

36 UCB is the blood left over in the umbilical cord and placenta after delivery. Typically, the
37 umbilical cord and placenta are thrown away as medical waste. UCB blood is similar to other
38 sources of blood because it contains red and white blood cells, platelets and plasma. It also contains

1 a special type of stem cell known as hematopoietic stem cells (HSCs) that can mature or grow into
2 different types of blood cells such as red blood cells, white blood cells, or platelets. Billions of
3 stem cells reside in just a few ounces of cord blood, which is collected painlessly from the
4 umbilical cord after birth. HSCs are used in treating life-threatening malignant and non-malignant
5 diseases of the blood and immune system.³ Researchers have found cord blood is effective in
6 treating up to 80 conditions.⁴ Moreover, clinical studies have proved the pluripotent nature of cord
7 blood cells, highlighting a wide range of possible clinical applications in neonatology, regenerative
8 medicine, and immune modulation.

9 10 *Umbilical Cord Blood Banking*

11
12 UCB banking has grown significantly in the past two decades. The option to bank UCB was first
13 made available in the 1990s following the discovery that cord blood is a rich source of stem cells.⁵
14 UCB banking consists of the collection and storage of the UCB from the placenta and umbilical
15 cord, soon after childbirth.⁶

16
17 Three types of UCB banks currently exist: public, private, and hybrid. Public banks store UCB
18 units received altruistically from donors, which are then listed on the Be The Match® Registry
19 (The Registry) and made available for any potential recipient if they are an adequate HLA match.⁷
20 There is no cost to donate the baby's cord blood to a public bank. Public banks follow strict quality
21 assurance and FDA regulations and will only bank cord blood if it is sterile and contains enough
22 stem cells to use in treatment. However, public cord blood banks do not allow directed storage. In
23 contrast, private banks, also referred to as family banks, store UCB for exclusive future use either
24 by the donor or a matched relative. When a baby's cord blood is stored in a private cord blood
25 bank, the donor pays collection and ongoing storage fees and the UCB is reserved for the donor's
26 use only. As the cord blood is being saved for personal use, private banks are not required to follow
27 the same quality and sterility guidelines as a public bank.⁸ Hybrid banks offer combined public and
28 private UCB storage solutions. In this scenario, either the private bank offers a public donation, or
29 the public bank offers a private storage option.

30 31 *Recruitment and Donor Education*

32
33 Public UCB banks are required to process, and store collected units within 48 hours of collection.
34 Therefore, collection tends to occur in geographically proximate hospitals, which is available in a
35 limited number of hospitals in the United States.⁹ This, coupled with the lack of funding for
36 marketing campaigns, means that recruitment and education of expectant parents provided by
37 public UCB banks is minimal, mostly consisting of websites to provide education and guidance to
38 expectant parents who want to donate their baby's cord blood. Most public UCB banks rely on the
39 voluntary participation of physicians, prenatal class instructors, and labor and delivery nurses to
40 encourage expectant parents to donate, provide information about donation, and to collect the cord
41 blood at the time of delivery. Some public UCBs maintain their own staff in collection hospitals to
42 provide information and education about cord blood donation or consent-and-obtain information
43 for the maternal questionnaire. Further, many states have laws requiring obstetricians to inform
44 their patients about cord blood banking.¹⁰ However, most legislation does not specify whether
45 public or private donation should be discussed.

46 47 *Cord Blood Collection, Processing, and Storage*

48
49 Families who decide to donate their newborn's cord blood to a public UCB bank must provide a
50 maternal health history and a maternal blood sample for infectious disease screening prior to
51 delivery. Collected cord blood is then packed, stored, and transported, typically in a temperature

1 monitored environment, to a cell-processing laboratory. While in transit from the collection site to
2 the processing and storage site, time and temperature affect the viability of the cord blood: One
3 study reported a 1-percent drop in cell viability for every 4-hour increase in transit time.¹¹ After
4 collection, but before further testing or processing, many public UCB banks perform an initial
5 assessment of the collected unit to determine its weight and volume. Low weight or volume units
6 are usually discarded or donated to research since they are unlikely to meet minimum cell count
7 requirements for banking and use in transplants.¹²

8
9 At any point in the process, a cord blood unit may be identified as unsuitable for storage for any
10 number of reasons, including low volume (i.e., not enough stem cells to use in a transplant), poor
11 viability (i.e., there may be stem cells, but they may not be alive or appropriately functioning), poor
12 results from infectious disease testing, or negative findings from the maternal health questionnaire.
13 Some studies have demonstrated that for every one-hundred births eligible for cord blood donation
14 in which cord blood collection is attempted, approximately forty-five are sent for processing and
15 approximately ten are ultimately stored.¹³

16 17 *Cord Blood Inventory Management and Withdrawal*

18
19 Most cord blood stored in public banks in the United States are listed with the National Marrow
20 Donation Program (NMDP), which runs The Registry and serves as a central site for patients
21 seeking HSC transplants of all kinds.¹⁴ Many international banks' cord blood is also available
22 through The Registry. Some public UCB banks may also offer units that do not meet qualifications
23 for being listed on The Registry but may still have value to potential recipients (i.e., they may have
24 lower cell counts, but represent rare HLA types). These are not available through The Registry, but
25 rather are obtained directly through established relationships with UCB banks.

26
27 When a patient has a condition that necessitates treatment using an allogeneic HSC transplant, the
28 patient's physician, whether in the United States or abroad, can search existing registries, including
29 The Registry, for a potential match. More than 90 percent of UCB units distributed for transplant in
30 the United States are distributed through The Registry.¹⁵

31 UMBILICAL CORD BLOOD REGULATION AND GOVERNMENT POLICIES

32 33 34 *Federal Policies and Programs*

35
36 In 1987, the National Bone Marrow Donor Registry (NBMDR) was initiated through a
37 congressionally directed grant from the U.S. Department of the Navy and formally established in
38 1990 as a responsibility of the U.S. Department of Health and Human Services (HHS), with
39 oversight initially by the National Institutes of Health (National Heart, Lung, and Blood Institute)
40 and, since 1994, by the Health Resources and Services Administration (HRSA).¹⁶ In December
41 2005, Congress passed the Stem Cell Therapeutic and Research Act (Stem Cell Act 2005).¹⁷ The
42 Stem Cell Act 2005 amended the Public Health Service Act and required the HHS Secretary,
43 through HRSA, to rewrite the provisions that established and maintained the NBMDR. The
44 provisions were rewritten to establish and maintain the C.W. Bill Young Cell Transplantation
45 Program (CWBYCTP), the successor to the NBMDR.

46
47 The Stem Cell Acts of 2005, 2010, 2015, 2021 authorized the following:

- 48
49 • The Stem Cell Therapeutic and Research Act of 2005 established the CWBYCTP to
50 replace the NBMDR. In so doing, the Act expanded on the previous requirements of the
51 NBMDR to increase the numbers of marrow donors and cord blood units and continued to

1 serve patients who need a bone marrow or umbilical cord blood transplant. The
 2 CWBYCTP also established an outcomes database to collect data and perform research, as
 3 well as offer patient and donor advocacy services, case management services, data
 4 collection on transplant outcomes, and educational activities.

- 5 • National Cord Blood Inventory (NCBI). The NCBI program contracts with cord blood
 6 banks to meet the statutory goal of building a public inventory of at least 150,000 new,
 7 high-quality, and genetically diverse UCB units.¹⁸ These UCB units are available for
 8 transplantation through the CWBYCTP. The Stem Cell Therapeutic and Research
 9 Reauthorization Acts of 2010 also required the U.S. Government Accountability Office to
 10 report on efforts to increase cord blood unit collection for the NCBI.
- 11 • Advisory Council on Blood Stem Cell Transplantation (ACBSCT). The goal of the
 12 ACBSCT is to advise, assist, consult with, and make recommendations to the Secretary of
 13 Health and Human Services and the Administrator of HRSA on matters carried out by both
 14 CWBYCTP and the NCBI Program.¹⁹

15 16 *HRSA*

17
 18 HRSA administers the CWBYCTP and manages its various components. HRSA provides funding
 19 for the collection of diverse cord blood units for NCBI through contracts to cord blood banks.
 20 There are 13 NCBI contractors who bid to provide a certain number of cord blood units of
 21 specified types (i.e., racial/ethnic groups).²⁰ Once NCBI-eligible cord blood units are listed on The
 22 Registry, public cord blood banks receive a subsidy for cord blood collection, processing, and
 23 storage. This subsidy does not cover the entire costs borne by cord blood banks for collection,
 24 processing, and storage, but it does help defray some of those costs.

25 26 *National Marrow Donor Program (NMDP)*

27
 28 The NMDP provides the link between HRSA, UCB banks, and physicians for obtaining stem cells
 29 and, specifically, cord blood. The NMDP also acts as the financial intermediary between individual
 30 UCB banks and hospitals and provides education for patients and clinicians.²¹

31 32 *FDA Oversight*

33
 34 The FDA regulates cord blood in a variety of ways, depending on the source, the processing, and
 35 the intended use. Cord blood stored in private banks (i.e., for autologous use or use in first- or
 36 second-degree relatives) does not need to go through FDA licensure because it is used on the
 37 individual from whom it was collected, or on a related individual. In contrast, public
 38 UCB banks store UCB units intended for use by a patient unrelated to the donor (i.e., for allogeneic
 39 use). Therefore, this use meets the legal definitions of both a “drug” and a “biological
 40 product,” which means that public UCB banks must adhere to additional requirements.^{22,23} Public
 41 banks are required to comply with good tissue practice regulations, conduct specific donor
 42 screening and infectious disease testing, conduct standardized testing on UCB units, and maintain
 43 international cellular therapy accreditation. Further, public UCB banks are required to hold
 44 licensure from the FDA. The costs and timeline for achieving FDA licensure are reportedly high,
 45 with many public UCB banks reporting a 12-to-24-month timeline, initial costs of approximately
 46 \$1 million, and ongoing annual costs of more than \$100,000.^{24,25}

47
 48 It is also important to note that individual UCB units are licensed, not the UCB bank itself.
 49 Most public UCB banks in the United States were in operation before the FDA licensure
 50 mandate—the FDA issued guidelines for licensure in 2009 and issued the first license in 2011.²⁶
 51 Licensed UCB units meet FDA standards, and unlicensed UCB units are collected and processed

1 prelicensure or are post-licensure collections that do not meet the requirements specified by the
 2 FDA. Public UCB banks that have not achieved FDA licensure will produce only unlicensed
 3 UCBs. Finally, UCB units from international banks are also unlicensed. The use of an unlicensed
 4 UCB unit must go through the process of an Investigational New Drug (IND) application.²⁷ An
 5 IND may be submitted by the UCB bank, the transplant physician, the transplant center, a national
 6 or international cord blood registry involved in coordinating the distribution, or another qualified
 7 sponsor.²⁷ INDs are granted only for specific uses.²⁶

8 9 *State Legislation*

10
11 To date, 28 states have passed some form of cord blood education legislation, which represents 78
12 percent of the total annual US births.¹⁰ Several other states are in various stages of developing
13 similar legislation to help inform health care professionals and expectant parents of all medically
14 appropriate options for preserving cord blood stem cells.

15 16 ADVANTAGES AND DISADVANTAGES OF USING CORD BLOOD STEM CELLS

17 18 *Advantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells*

19
20 Physicians and patients balance trade-offs when choosing a suitable stem cell donation for
21 transplant. In some cases, the urgency to perform the transplant makes cord blood stem cells the
22 preferred choice because they are usually available for overnight transport once a suitable match is
23 identified.²⁸ Other factors to consider include time to acquire the donation and quality of the
24 potential stem cell sources, as well as the patient's age and disease. One major advantage to using
25 cord blood stem cells is the fact that they are less differentiated than stem cells from adult sources
26 (i.e., bone marrow or peripheral blood), and therefore are better able to develop into various cell
27 types as they mature. This quality is an asset for transplantation because cord blood stem cells
28 require less-stringent donor-recipient matching than adult stem cells and carry a lower risk for
29 rejection by the recipient's body. Another advantage is that this less-strict matching also implicitly
30 increases access to stem cells as a treatment source for those unable to find suitable matches among
31 other sources.²⁹ This is especially important for racial and ethnic minorities who often have a hard
32 time finding a suitable donor.

33
34 Bone marrow and peripheral blood stem cell collection also have disadvantages. Preparations for
35 collection of bone marrow or peripheral blood, such as donor-recipient matching to minimize the
36 chance of rejection, can take several weeks to complete. Collection itself requires the donor to
37 undergo a procedure requiring sedation, typically done in an operating room, or take medication to
38 stimulate stem cell production, both of which can be painful and can require recovery in the
39 hospital.³⁰

40 41 *Summary of Advantages for Patients*

42
43 For certain patients, there may be advantages to using donor cord blood stem cells instead of donor
44 peripheral blood or donor marrow stem cells. Some potential advantages include:

45
46 Availability. Cord blood stored in a public cord blood bank has been prescreened, tested and frozen
47 and is ready to use. They are usually available for overnight transport once a suitable match is
48 identified.³¹

49
50 Human Leukocyte Antigen (HLA) Matching. The outcomes of related and unrelated donor stem
51 cell transplants are strongly affected by the degree of HLA matching between the transplant

1 recipient and the donor cord blood. HLA matching plays an important role in successful
2 engraftment, severity of graft-versus-host disease (GVHD) and overall survival. A close match
3 between the patient and the cord blood unit can improve a patient's outcome after transplantation.³¹
4

5 Graft-Versus-Host Disease. Studies have found that after a cord blood stem cell transplant, fewer
6 patients got GVHD and, among those patients who did develop GVHD, the complication tended to
7 be less severe than it was in patients who had bone marrow or peripheral blood transplants. GVHD
8 is a serious and sometimes fatal complication of allogeneic stem cell transplantation.³¹
9

10 Diversity. As a result of extending collection efforts to hospitals where births from diverse ethnic
11 backgrounds are well represented, donated cord blood units have the potential to provide a source
12 of stem cells that reflect racial and ethnic diversity.³¹
13

14 Infectious Disease Transmission. Cord blood stem cell transplants carry a lower risk of
15 transmission of blood-borne infectious diseases compared with stem cells from the peripheral
16 blood or marrow of related or unrelated donors.³¹
17

18 *Disadvantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells*

19

20 Although the U.S. government started a federal cord blood program in 2005 to help create a
21 nationwide inventory of high quality and genetically diverse units of cord blood, the proportion of
22 cord blood stem cell transplants relative to transplants using other types of stem cells, such as those
23 from bone marrow, has been falling in recent years.³² The declining demand and increasing costs
24 has led to some of the public UBC banks to struggle to operate financially.
25

26 One significant disadvantage to using cord blood stem cells is that the volume of collectible blood
27 is small in comparison to that from an adult donor's bone marrow or peripheral blood. Fewer stem
28 cells means that it takes approximately 10–15 days longer than other sources for the stem cells to
29 establish themselves when introduced in the recipient's bone marrow.³³ This means longer
30 recovery time in the hospital for the recipient. Since bone marrow and peripheral blood can provide
31 more stem cells per donation, the cells usually engraft more quickly in the recipient's bone marrow,
32 so the recipient typically has a shorter recovery period. Further, bone marrow or other peripheral
33 blood stem cells are not required to be licensed.
34

35 *Summary of Disadvantages for Patients*

36

37 Clinical Data. Cord blood stem cell transplantation is almost two decades old yet is a relatively new
38 procedure in comparison to transplantation of peripheral blood or marrow stem cells. It is possible
39 that genetic diseases may be present but not apparent at the time of birth and could be transplanted
40 to a patient via donor cord blood stem cells. Procedures to track this possibility require follow-up
41 until the donor infant is months or even years old, but such follow-up has proven difficult. A future
42 approach to address this may be genetic testing for diseases that affect the blood and immune
43 system and for certain metabolic diseases that might be transplantable.³¹
44

45 Storage. It is not known how long cord blood can be frozen and stored before it loses its
46 effectiveness. Cord blood samples have been preserved for as long as 10 years and have still been
47 successfully transplanted.³¹
48

49 Engraftment. The number of cells required to give a transplant patient the best chance for
50 engraftment and for surviving the transplant is based on his or her weight, age and disease status. A
51 cord blood unit might contain too few stem cells for the recipient's size. Due to the smaller number

1 of stem cells in the cord blood unit, cord blood stem cell transplants engraft more slowly than stem
2 cells from marrow or peripheral blood. Until engraftment occurs, patients are at risk of developing
3 life-threatening infections due to immunosuppression from chemotherapy and/or radiation intended
4 to prepare the recipient for the transplant. Thus, cord blood transplant recipients may be vulnerable
5 to infections for an average of up to one to two months longer than marrow and peripheral blood
6 stem cell recipients.³¹

7 8 CURRENT DEMAND FOR CORD BLOOD UNITS

9
10 Overall, stem cell transplants have been on the rise for several years. However, the number of
11 transplants using cord blood has declined over time, from about 12 percent of all HSC transplants
12 to about 8 percent from 2010 to 2015.³⁴ As of 2020, more than three-quarters (77%) of the
13 unrelated transplants and three-quarters (80%) of related transplants were performed using
14 peripheral blood.³⁵ One-seventh (14%) of unrelated transplants used bone marrow and 7% used
15 cord blood units.³⁵ Other factors may contribute to the declining demand for cord blood, such as
16 higher procurement and treatment costs or provider preferences. Over the short term, treatment
17 costs are clearly higher for cord blood transplants relative to other stem cell transplants. This is
18 primarily driven by longer engraftment periods, which translate into longer hospital stays. Research
19 is still needed to determine whether cord blood recipients stay healthier over the long term than
20 recipients of other stem cell types. Further, differences in collection costs are also unclear, as
21 previous studies have tended to ignore the cost of harvesting adult stem cell sources, which can be
22 significant.³⁴

23
24 Competition among public banks has increased as the net supply of cord blood units has grown.
25 Private banks, in which individuals store cord blood for their own family use, also provide some
26 competition because their units may not be released to the national inventory, keeping that segment
27 of the market off-limits for most patients. In addition, international cord blood banks now supply
28 about 24 percent of units used in the United States, up from 13 percent in 2004.³⁶ The fee that a
29 bank charges a transplant center for a cord blood unit tends to be the same (about \$36,000)
30 regardless of the unit's TNC count or genetic rarity.³⁴ The current market environment for public
31 banks makes it difficult to break even. Costs for public banks include processing, testing, and
32 storage costs; licensure by the U.S. Food and Drug Administration; and overhead costs. The total
33 expenses vary widely, ranging from \$1 million to \$6 million, depending on the size of the
34 operation.³⁷ Further, revenue primarily comes from fees, but also from the NCBI subsidies for
35 registered units, donations, grants, or in-kind donations of services. Banks collect, on average,
36 8,500 units annually but ultimately store only 5 to 40 percent of those collections.³⁸ Among units
37 that have been banked, a low-TNC-count unit has only about a 0.1-percent chance of being used in
38 a given year, as opposed to a 3-percent chance for larger units.³⁷ Because banks collect fees only on
39 units that are used, banks that store low-TNC-count units are more likely to lose money.

40 41 EQUITY CONSIDERATIONS

42
43 In the U.S., racial minorities are much less likely to find a suitable blood stem cell donor than
44 White Americans. For example, a Black person has a 29 percent chance of finding a matched donor
45 in the registry, while a white person has a 79 percent chance.³⁹ People who are American Indian
46 and Alaska Native have a 60 percent chance of finding a registry match, Asian and Pacific Islander
47 patients 47 percent, and Hispanic or Latino patients 48 percent.³⁹ People of color make up a small
48 percentage of all donors, making it difficult to find matches for people with cancer who are not
49 white or who are of mixed race and ethnicity.

1 HSCs from UCB offer the advantage of requiring less stringent HLA-matching criteria (i.e., six
2 loci, rather than 10 as is the case for bone marrow derived HSCs). In addition, since these cells can
3 be cryopreserved, this provides an off-the-shelf solution to patients in urgent need of
4 transplantation. These factors are particularly advantageous for patients from non-Caucasian racial
5 and ethnic groups, especially since this offers access to a worldwide inventory and increased the
6 likelihood of finding a match.^{40,41}

7
8 As discussed above, one disadvantage of using UCB is the low yield of HSCs when compared to
9 bone marrow or peripheral blood. Use of a suboptimal HSC cell dose results in delayed recovery,
10 higher graft failure rates and risk of infection.^{45,42} This results in increased hospitalization times
11 and a consequent increase in treatment costs. Double UCB transplantation is often employed to
12 overcome this, causing significant financial burdens to the transplant recipient. The cost factor is
13 particularly pertinent in the context of allogeneic UCB transplantation, when one considers that
14 obtaining a single UCB unit can cost up to \$36,000.⁴³ The costs of double UCB unit transplantation
15 and further manipulations can therefore be prohibitively expensive.

16 17 POTENTIAL COST CONSIDERATIONS

18
19 Limited information is available about the costs to set up an UCB donation systems in health care
20 settings where a program currently does not exist. As noted above, public UCB banks are required
21 to process, and store collected units within 48 hours of collection. This is essential to maintain the
22 viability of the collected cells. Therefore, this may only be feasible when a public UCB bank is
23 geographically proximate to the hospital. There are significant costs for hospitals to set up public
24 UCB donation centers on site. One example of the potential fiscal cost comes from Connecticut
25 which aimed to establish a public UCB bank between the Department of Public Health (DPH) and
26 the University of Connecticut Health Center (UCHC).⁴⁴ The estimated costs were \$1.9 million,
27 with ongoing annual operating costs of \$2.38 million for the subsequent years.⁴³ These estimates
28 assumed a volume of 1,440 specimens to be collected and stored per year and included costs for
29 personnel, equipment, training, accreditation, reagents, rent, vehicles for transport, freezers, testing,
30 courier services, and computer maintenance.⁴³

31
32 Public UCB banks with donation systems in place incur both variable and fixed costs. Variable
33 costs include costs of collection, testing, processing, storing, and distributing the unit.³⁷ Fixed costs
34 include obtaining FDA licensure and overhead costs, such as rent.³⁷ Collection costs include costs
35 of recruiting donors, collection kit supplies, and labor costs. These costs may vary based on
36 the recruitment efforts conducted, as well as whether the bank uses volunteer CBU collectors, or
37 whether it employs its own CBU collectors. There are also significant costs at the processing stage,
38 including separation of the CBU components and HLA-typing to prepare the units for storage.³⁷
39 Further, the costs banks typically incur to obtain the FDA license are not publicly available.
40 Therefore, average annual overhead costs—which consist of equipment costs, maintenance, rent,
41 utilities, office supplies, and other related expenses—total from \$1.2 million to \$4.5 million,
42 depending on the size and setup of the UCB bank.³⁷

43
44 Revenue comes primarily from fees, but also from the NCBI subsidies for registered units,
45 donations, grants, or in-kind donations of services. Banks collect, on average, 8,500 units annually
46 but ultimately store only 5 to 40 percent of those collections.³⁴ Because banks collect fees only on
47 units that are used, banks that store low-TNC-count units are more likely to lose money. Banks
48 have had to get creative with how they structure their businesses to remain viable. Some banks
49 have adopted hybrid models, offering private family banking to cross-subsidize the nonprofit
50 public banking operations under NCBI.³⁴ Some have also improved their financial situation by
51 selling their processing or testing services to private banks.³⁴ Others are part of larger

1 organizations, such as whole blood centers or hospitals, which can offer cheaper transportation and
2 lab work.³⁴ Despite the current financial limitations, one study calculated that the average annual
3 value of having a national public bank system range from \$883 million to \$1.7 billion, far
4 outweighing the aggregate industry operational costs of \$60 million to \$70 million to maintain the
5 current system.³⁴

6
7 Other limitations to collecting UCB include the lack of delivery rooms, licensed obstetric nurses,
8 and the need for more extended opening hours at the local public cord blood bank.⁴⁵ This highlights
9 the other potential cost considerations that might increase UCB donations at current hospitals with
10 existing systems set up.

11 12 FEDERATION OF MEDICINE POLICY

13
14 The American College of Obstetricians and Gynecologists support public UCB donations and state
15 that public banking is the recommended method of obtaining cord blood. They further state that the
16 routine use of private cord blood banking is not supported by available data.⁴⁶ In addition, the
17 importance of contributions from all ethnicities and races to public banks is highlighted. The
18 American Academy of Pediatrics also supports the use of public cord blood banking, and further
19 state that it is the preferred method of collecting, processing, and using cord blood cells for use in
20 transplantation in infants and children with fatal diseases, such as malignancies, blood disorders,
21 immune deficiencies, and metabolic disorders.⁴⁷

22 23 *Existing AMA Policy*

24
25 The AMA has policy addressing the use of cord blood for transplantation. Code of Medical Ethics
26 6.1.5 “Umbilical Cord Blood Banking” states that cord blood is a potential source of stem and
27 progenitor cells with possible therapeutic applications. Further it states that “physicians who
28 provide obstetrical care should be prepared to inform pregnant women of the various options
29 regarding cord blood donation or storage and the potential uses of donated samples.” It also
30 encourages donation to a public bank. The Code of Medical Ethics 7.3.8 “Research with Stem
31 Cells” urges physicians who conduct research using stem cells obtained from any source
32 (established tissue, umbilical cord blood, or embryos) to adhere to institutional review board (IRB)
33 requirements, ensure that the research is carried out with appropriate oversight and monitoring,
34 ensure that the research is carried out with appropriate informed consent.

35
36 AMA Policy H-370.970 “Umbilical Cord Blood Transplantation: The Current Scientific
37 Understanding” urges physicians to recognize the viability of UCB transplantation as an alternative
38 to bone marrow transplantation. It also encourages the education of physicians and the public on
39 UCB donation. Finally, AMA Policy H-370.956 “Increasing Public Umbilical Cord Blood-
40 Donations in Transplant Centers” encourages the availability of altruistic cord blood donations in
41 all states and access to public cord banking and the creation of public cord blood banks to support
42 altruistic cord blood donation.

43 44 CONCLUSION

45
46 The UCB field has come a long way after 30 years of biomedical and clinical research supported
47 by public and private cord blood banking. Over 40,000 UCB transplants have been performed, both
48 in children and in adults, for the treatment of around 80 different medical disorders. Cord blood
49 banking has been developed to the point that around 800,000 units are being stored in public banks
50 and over 4 million units in private banks worldwide. Although UCB units are not the answer for
51 every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients

1 every year who have no alternative treatment modality. Particularly, cord blood transplants can be
2 critical for pediatric and minority populations. Although sometimes there are alternatives to cord
3 blood, patients often have no appropriate alternative HSC source. In addition, the importance of
4 getting treatment quickly for some patients can make UCB units the best choice compared with
5 other HSC sources that require greater lead time.

6
7 Changes in technology or new research findings related to the use of HSCs might increase or
8 decrease the future use of cord blood. Although clinical trials using cord blood typically address
9 rare diseases, research efforts are underway studying new cord blood applications to treat diabetes,
10 traumatic brain injury, stroke, cerebral palsy, and autism. Any new medical applications for cord
11 blood could increase demand for UCB units. There is also research on HSC expansion and related
12 technologies that could increase the utility of small CBUs.

13
14 Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One
15 notable barrier is that public UCB banks are required to process, and store collected units within 48
16 hours of collection. This limits the collection sites to proximally located hospitals. This provides a
17 barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This,
18 coupled with the lack of funding for efforts to improve recruitment and education of expectant
19 parents, leads to insufficient UCB donations and availability for transplant. Most public UCB
20 banks rely on voluntary participation of staff to encourage expectant parents to donate, provide
21 information about donation, and to collect the cord blood at the time of delivery. It should be noted
22 that time of delivery is not optimal for appropriate consent, adding another limitation to umbilical
23 cord blood donation. Further, some public UCBs maintain their own staff in collection hospitals
24 with collection sites to provide information and education about cord blood donation.

25 26 RECOMMENDATIONS.

27
28 The Council on Science and Public Health recommends the following be adopted, and the
29 remainder of the report be filed.

- 30
31 1. That our AMA amend Policy H-370.956 “Increasing Public Umbilical Cord Blood-
32 Donations in Transplant Centers” as follows:
- 33 1. Our AMA encourages: (1) the availability of altruistic cord blood donations in all
34 states; ~~and~~ (2) access to public cord banking and the creation of public cord blood
35 banks to support altruistic cord blood donation; (3) all hospitals that provide
36 obstetrics services work to provide access to public (altruistic) umbilical cord
37 blood donation; (4) that when available, to reduce barriers through education of
38 patients about altruistic umbilical cord donation; and (5) that hospitals providing
39 obstetrics services and umbilical cord blood banking facilities work together to
40 create networks to expand access to and increase efficiency of altruistic umbilical
41 cord donations.
 - 42 2. Our AMA supports federal funding efforts to increase knowledge sharing across
43 banks and mentoring for centers, physicians, and staff with minimal experience in
44 cord blood collection.
 - 45 3. AMA advocates for increased federal and state funding for public UCB banks to
46 create networks to expand access to and increase efficiency of altruistic umbilical
47 cord donations in areas lacking the appropriate infrastructure to effectively collect
48 umbilical cord blood donations.
 - 49 4. Our AMA supports efforts to educate physicians about best practices in collecting
50 public umbilical cord blood donations.

- 1 5. Our AMA encourages efforts to increase the diversity of the national inventory of
2 umbilical cord blood through funding that supports banks to add collection sites
3 where more racial and ethnic minority cord blood units can be collected. (Modify
4 Current HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 06 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or
Corrections
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. AMA Policy D-430.993, “Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections,” as adopted by the House of Delegates (HOD), asked that our American Medical Association (AMA) study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody are provided the autonomy and privacy protections afforded to them by law and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “acute care of patients in custody”, “acute care AND corrections,” and “acute care AND incarceration.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND. The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated nationwide. Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for individuals who are incarcerated. Few states have stand-alone hospitals for incarcerated patients, and in some counties, health departments offer expanded on-site services in their jails, including urgent care facilities. However, when medical care required by an individual who is incarcerated exceeds the capabilities of the correctional facility’s health care services, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients in custody, and face unique medical, legal, and ethical issues.

This report primarily focuses on acute care for patients who interact with law enforcement. It outlines the constitutional rights to health care for incarcerated individuals and the rights for privacy of health information, as well as when that health information may be disclosed. The report also provides recommendations in support of developing standardized best practices and provides best practices should ensure security measures do not interfere with the capacity to provide care for incarcerated individuals.

CONCLUSION. Information on best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. The National Commission on Correctional Health Care remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 06 -A-23

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

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 American Medical Association (AMA) Policy D-430.993, “Study of Best Practices for Acute Care
2 of Patients in the Custody of Law Enforcement or Corrections,” as adopted by the House of
3 Delegates (HOD), asked that our AMA study best practices for interactions between hospitals,
4 other acute care facilities, clinicians, and members of law enforcement or correctional agencies to
5 ensure that patients in custody of such law enforcement or correctional agencies (including patients
6 without decision-making capacity), their surrogates, and the clinicians caring for them are provided
7 the autonomy and privacy protections afforded to them by law and in concordance with
8 professional ethical standards and report its findings to the AMA House of Delegates by the 2023
9 Annual Meeting.

10
11 BACKGROUND

12
13 The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated
14 nationwide.¹ People of color are incarcerated at higher rates in jails and prisons across the country,
15 which causes disproportionate economic, health, and social harms.²

16
17 Incarcerated individuals typically have high rates of psychiatric conditions, communicable
18 diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for
19 individuals who are incarcerated. Correctional facilities offer a range of health care services from
20 primary care to hospital-level care. Few states have stand-alone hospitals for incarcerated patients,
21 and in some counties, health departments offer expanded on-site services in their jails, including
22 urgent care facilities. However, when medical care required by an individual who is incarcerated
23 exceeds the capabilities of the correctional facility’s health care services, that individual is
24 transferred to a contracted hospital or, in emergent cases, to the nearest health care institution.
25 Health care professionals practicing outside of correctional facilities receive little dedicated
26 training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients
27 in custody, and face unique medical, legal, and ethical issues.

28
29 This report is specifically focused on acute care of patients in custody. Acute care is defined as a
30 patient who is treated for a brief but severe episode of illness, for conditions that are the result of
31 disease or trauma, and during recovery from surgery.³ Acute care is generally provided in a
32 hospital by a variety of clinical personnel using technical equipment, pharmaceuticals, and medical
33 supplies to provide diagnosis, care and treatment of a wide range of acute conditions, including
34 injuries.⁴

1 METHODS

2
3 English language articles were selected from searches of PubMed and Google Scholar using the
4 search terms “acute care of patients in custody”, “acute care AND corrections,” and “acute care
5 AND incarceration.” Additional articles were identified by manual review of the reference lists of
6 pertinent publications. Web sites managed by government agencies and applicable organizations
7 were also reviewed for relevant information.

8
9 DISCUSSION

10
11 *Health of incarcerated populations*

12
13 Compared to the general population, individuals with a history of incarceration have worse mental
14 and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and
15 infectious diseases, such as tuberculosis, hepatitis C, and HIV.^{4,5} Several factors contribute to the
16 prevalence of mortality due to illness and disease in this population. The incarcerated population is
17 largely drawn from the most disadvantaged segments of society, with significant health care needs
18 but limited access to regular care.⁶ As a result, many incarcerated individuals arrive at correctional
19 facilities in poor health with conditions that were previously undiagnosed.

20
21 Once incarcerated, the conditions of confinement often have a negative impact on health. Stress
22 associated with institutional life, overcrowding, inadequate access to exercise, improper diet,
23 exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality.
24 Further, while incarcerated individuals have a constitutional right to health care, the access to and
25 the quality of the care in correctional facilities are variable.⁷ Insufficient resources play a key role
26 here, especially limited budgets and regulations that require correctional facilities to prioritize
27 treating certain diseases over others. Some facilities tend to focus on those medical conditions that
28 have immediate and broad impact within the facility, such as HIV and tuberculosis, but also have
29 the potential to spill over into the general population. As a result, treatment of other chronic
30 conditions, such as diabetes and heart or kidney problems, may drop in priority.⁸ With few
31 exceptions, nearly all chronic health conditions are more prevalent among incarcerated individuals
32 than the general population. Finally, a major need is increased medical capacity in correctional
33 facilities. Mortality could be reduced if facilities were better equipped to detect acute chronic
34 conditions, such as elevated blood pressure, and respond with adequate care.⁹

35
36 Women with a history of incarceration face a greater burden of disease than men with a history of
37 incarceration.^{10,11} For example, female offenders with a history of drug misuse were more likely
38 than their male counterparts to suffer from conditions such as tuberculosis, hepatitis, and high
39 blood pressure.^{21,22} Women with a history of incarceration are also at greater risk for HIV/AIDS,
40 HPV, and other sexually transmitted diseases.^{21,22} Women with a history of incarceration are also
41 more likely to have experienced childhood trauma and physical and sexual abuse than women who
42 are not involved in the criminal justice system, potentially explaining high levels of physical and
43 mental health problems among women who are incarcerated.²²

44
45 The number of older adults (ages 50 years and above) in U.S. prisons is growing.^{12,13} Many
46 correctional facilities, however, are not equipped to address the special health needs of these
47 individuals.²³ While incarcerated, some older adults do not receive adequate treatment for their
48 ailments, particularly mental health conditions.^{23,14} For example, one study found that only 18
49 percent of older adults who are incarcerated were prescribed medication to treat their mental health
50 conditions.²⁵

1 *Constitutional right to correctional health care*

2
3 Incarcerated individuals oftentimes need medical attention for ailments, injuries, and diseases.
4 However, there can be misconceptions about an incarcerated individuals' medical rights among
5 physicians, medical administrators, prison and jail staff, and law enforcement officials. There have
6 been several landmark rulings regarding health care and incarceration. Two of the major cases are
7 *Estelle v. Gamble*, (1976) and *Farmer v. Brennan*, (1994).^{15,16} In *Estelle*, the U.S. Supreme Court
8 held that failure to provide adequate medical care to incarcerated people as a result of deliberate
9 indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment.⁵
10 The Supreme Court's decision in *Farmer* held that a prison official's deliberate indifference to a
11 substantial risk to a prisoner violated the Eighth Amendment and resulted in cruel and unusual
12 punishment.⁶ These two cases provide guidance regarding the legal standards for access to health
13 care and deliberate indifference under the Eighth Amendment, but did not define the minimum
14 standards of for medical care in prisons and jails, or a prisoner-patient's rights in medical decision-
15 making.^{5,6} In practice, the standard for establishing an Eighth Amendment violation is very
16 challenging to meet. Federal courts have stated that to constitute deliberate indifference, "treatment
17 must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be
18 intolerable to fundamental fairness."¹⁷

19
20 *Clinical best practices*

21
22 Best practices and management of medical conditions among hospitalized patients who are
23 incarcerated or interact with law enforcement is limited and primarily focuses on the care of
24 pregnant individuals. This demonstrates the need to create evidence-based guidelines in the acute
25 care setting for individuals who are incarcerated or who interact with law enforcement, and these
26 guidelines should balance the rights of the patient, the needs of the clinician, and the safety of the
27 institution and law enforcement. Multiple agencies at federal, state, and local levels possess
28 authority over correctional health care. The Federal Bureau of Prisons (BOP) oversees the
29 provision of medical, dental, and mental health services in federal prisons. The vast majority of the
30 incarcerated, however, are held in state prisons and county jails, where standards vary by state and
31 by county. Some facilities are accredited by private organizations, but this accreditation process
32 remains entirely voluntary, leaving the correctional health care system without a uniform set of
33 standards.

34
35 *National Commission on Correctional Health Care (NCCHC)*

36
37 Several professional organizations, including the American Medical Association, the American
38 Public Health Association, and later, the National Commission on Correctional Health Care
39 (NCCHC), have since established national standards for correctional health care.²⁷ NCCHC's
40 origins date to the early 1970s, when an American Medical Association study of jails found
41 inadequate, disorganized health services and a lack of national standards. In collaboration with
42 other organizations, the AMA established a program that in 1983 became the NCCHC, an
43 independent, 501(c)(3) nonprofit organization.¹⁸ Forty years later, NCCHC remains dedicated to
44 improving correctional health care quality. This is done by establishing rigorous standards for
45 health services in correctional facilities, operating a voluntary accreditation program for institutions
46 that meet those standards, offering certification for correctional health professionals, conducting
47 educational conferences and webinars, and producing industry-specific publications and other
48 resources.¹⁸

49
50 NCCHC's standards have provided uniquely valuable guidance to help correctional health
51 professionals and administrators improve the health of their incarcerated populations (and the

1 communities to which they return), increase efficiency of health services delivery, strengthen
 2 organizational effectiveness, and reduce the risk of adverse legal judgments.¹⁸ Established by
 3 health, mental health, legal, and corrections professions, NCCHC’s standards cover the areas of
 4 patient care and treatment, governance and administration, personnel and training, safety and
 5 disease prevention, special needs and services, and medical-legal issues.¹⁸ The NCCHC is
 6 impartial, unbiased, and dedicated only to recognizing and fostering quality in correctional health
 7 care. NCCHC is the only accrediting body authorized by the Substance Abuse and Mental Health
 8 Services Administration that focuses on corrections.¹⁸

9
 10 *Medicaid Inmate Exclusion Policy*

11
 12 The Medicaid Inmate Exclusion Policy, established in the 1965 Social Security Amendments,
 13 almost completely prohibits the use of federal Medicaid funding to care for incarcerated patients.
 14 As a result, there is no incentive for correctional facilities that seek accreditation, and voluntary
 15 accreditation rates remain low.¹⁹ Facilities often cite staff shortages and monetary and time costs as
 16 barriers to accreditation.²⁰ CMS has approved a first-of-its-kind Section 1115 demonstration
 17 amendment allowing Medicaid to fund limited services for people incarcerated in California state
 18 prisons, jails, and juvenile detention centers up to 90 days before their release.²¹ Under the
 19 amendment, the state will seek to increase coverage, continuity of care, and service uptake in
 20 carceral settings. Ten other states have applied for similar waivers, and bills in Congress seek to
 21 provide a pathway to Medicaid coverage for all incarcerated individuals approaching release.

22
 23 *Health care privacy*

24
 25 The year 1996, marked the enactment of the Health Insurance Portability and Accountability Act
 26 (HIPAA) which would later be amended to provide clear guidelines regarding the privacy of a
 27 patient’s medical records.¹ A main purpose of the Act was the protection of patient health
 28 information (PHI) when it was electronically received, handled or shared among health care-related
 29 agencies and individuals. HIPAA specifies that certain entities that engaged in those processes are
 30 “covered entities.”²² In general, a covered entity is defined as an agency that 1) electronically
 31 transmits health care information for the purpose of reporting; 2) requests to review PHI in order to
 32 secure authorization for the care of patients; and 3) electronically transmits PHI for the benefit of
 33 payment and claims from a public or private entity.²³ However, there is confusion regarding the
 34 privacy rights of incarcerated patients that needed clarification.

35
 36 The unique circumstances of incarceration required a separate section under the Act. That section,
 37 titled “Correctional institutions and other law enforcement custodial situations,” addresses
 38 permitted disclosures of PHI for prisoners.²⁴ The language in the section is very broad to permit
 39 disclosure in many circumstances. Covered entities may disclose the PHI of inmates without their
 40 authorization to correctional institutions or law enforcement officials who have lawful custody of
 41 an inmate for the purpose of providing health care to the inmate or for the health and safety of the
 42 inmate, other inmates, the officers and employees of the institution and others at the facility, and
 43 those responsible for inmate transfer.²⁵ Covered entities may also disclose the PHI of inmates
 44 without authorization for law enforcement purposes on the premises of an institution and for the
 45 administration and maintenance of the safety, security, and good order of the institution.⁹ These
 46 provisions apply only to the release of the PHI of current inmates.⁹

47
 48 Situations where information may be released include:

- 49
- 50 • Court-Ordered Subpoenas, Warrants, or Summons: A hospital may release patient
- 51 information in response to a warrant or subpoena issued or ordered by a court, or a

- 1 summons issued by a judicial officer. The hospital may disclose only that information
 2 specifically described in the subpoena, warrant, or summons.¹⁷
- 3 • Grand Jury Subpoenas: A hospital also may disclose patient information in response to a
 4 subpoena issued by a grand jury. Only information specifically described in the subpoena
 5 may be disclosed.¹⁷
 - 6 • Administrative Requests, Subpoenas, or Summons: An administrative request, subpoena,
 7 or summons is one that is issued by a federal or state agency or law enforcement official,
 8 rather than a court of law.¹⁷
 - 9 • Disclosures for Identification and Location Purposes: In response to a request by a law
 10 enforcement official, a hospital may release certain limited information to the official for
 11 purposes of identification and location of a suspect, fugitive, material witness, or missing
 12 person.¹⁷
 - 13 • Victims of a Crime: In response to a request by a law enforcement official, a hospital may
 14 disclose information to the official about a patient who may have been the victim of a
 15 crime, if the patient agrees to the disclosure. Such agreement may be oral but should be
 16 documented.¹⁷
 - 17 • Custodial Situations: A hospital may disclose to a correctional institution or a law
 18 enforcement official having lawful custody of an inmate or other individual information
 19 about such inmate or individual if the institution or official represents that such information
 20 is necessary for the health and safety of the individual.¹⁷

21
 22 When inmates are released, they have the same privacy rights under HIPAA as all other
 23 individuals. Additionally, exclusions exist for safely transporting prisoners to and from medical
 24 facilities. Further, HIPAA also includes provisions regarding inmates' ability to exercise
 25 protections otherwise granted in the rule. Inmates are excluded from the right to receive notice of
 26 possible uses and disclosures of PHI and of their rights and a covered entity's duties with respect to
 27 PHI. HIPAA's notice requirement does not apply at all to correctional institutions that qualify as
 28 covered entities.²⁶ Inmates have no right to notice regarding PHI created during incarceration, and
 29 correctional institutions are not required to send notices to inmates after release.

30
 31 *Medical Decision-Making*

32
 33 All patients, including people who are incarcerated, have the right to make their own health care
 34 decisions, including the right to refuse medical care. They also have the right to designate who
 35 should make their medical decisions if they become incompetent or incapacitated.²⁷ All patients
 36 and their appointed surrogate medical decision-makers, have the right to be properly informed of
 37 medical conditions, prognosis, diagnosis, risk and treatment alternatives through the process of
 38 informed consent. Wardens, guards, sheriffs, and police officers are not court-appointed legal
 39 guardians and therefore cannot make medical decisions on behalf of incarcerated patients.¹²

40
 41 Incarcerated individuals can appoint a surrogate medical decision-maker through a written advance
 42 directive, medical power of attorney, or an oral order.¹² Upon intake into a prison or jail, the
 43 incarcerated individual should be asked to list a medical decision-maker. If not asked by officials,
 44 the individual can request that such a decision-maker be listed in their medical records.¹²
 45 Physicians and medical staff have an ethical and legal duty to adhere to the patient's decisions,
 46 including through a surrogate decision-maker. Often, there is a misunderstanding among health
 47 care professionals, jail and prison administrators, and law enforcement officials that health care
 48 decisions can be made by wardens, sheriffs, guards, or police officers if an incarcerated patient is
 49 incapacitated. Under medical ethics and most state laws, those officials do not have medical
 50 decision-making authority for incapacitated prisoners.

1 An area of frequent confusion in medical decision-making for people who are incarcerated involves
2 a legally eligible or appointed surrogate decision-maker that is neither known and/or available.²⁸
3 This can be problematic when people are experiencing housing insecurity or are under the
4 influence of drugs or alcohol when arrested. In cases when doctors and corrections officials do not
5 know a legally eligible or appointed medical decision-maker, states have codified the legal
6 hierarchy of medical-decision making through various statutes.¹³ Many states recognize that
7 medical decisions for an incapacitated patient, without an appointed medical surrogate or proxy,
8 should be made on a familial basis. If a legal appointed medical decision-maker cannot be located,
9 then a court must appoint one on behalf of the patient through the legal guardianship process.

10
11 In the event of a medical emergency, any contact, advance directive or guardianship information
12 that corrections or law enforcement officials have for a prisoner-patient should be given to medical
13 staff at the prison or jail infirmary or local hospital.²⁹ Prison and law enforcement officials must
14 refrain from making medical treatment decisions on behalf of incarcerated patients, and doctors
15 must refrain from following treatment decisions made by such officials. It may even be necessary
16 for the hospital to use various means to attempt to determine the medical decision-maker if no
17 information is available from the patient, such as requesting their prison or jail medical records or
18 intake information.¹⁴ Regardless, physicians cannot delegate to prison and law enforcement
19 officials a prisoner-patient's medical decision-making authority. Those officials can make
20 recommendations regarding the safety of patients or physicians either in the prison or jail infirmary
21 or local hospital, but such recommendations should not interfere with the patient's treatment
22 protocol.¹⁴ If information is not available through an advance directive, appointed decision-making
23 surrogate or lineage, the healthcare staff will have to default to the best medical interest standard
24 for the prisoner-patient's care.

25 26 *Forcible Medical Procedures*

27
28 Several alarming cases of forced medical procedures performed on prisoners, in the form of
29 surgery or body cavity searches, have been reported. In *Sanchez v. Pereira-Costillo*, the First
30 Circuit Court of Appeals agreed with the plaintiff, that a surgical procedure conducted by doctors
31 at the direction of corrections officials in Puerto Rico had violated his rights.³⁰ Prison staff thought
32 that the plaintiff had a cell phone hidden in his rectum. Despite X-rays and bowel movements
33 indicating there was no phone, staff at the Río Piedras Medical Center performed exploratory
34 surgery at the request of prison officials. The Court of Appeals noted in its opinion that "the
35 exploratory surgery of his abdomen" violated the plaintiff's rights under the Fourth Amendment.¹⁵
36 Furthermore, one issue that affects prisoners with respect to forced treatment, involuntary body
37 cavity searches and medical decision-making is a doctor's dual loyalties, which can be problematic
38 in correctional health care.³¹ Physicians may work as employees or contractors at prisons and jails,
39 and sometimes have conflicts of interest between their patients and employer.

40 41 *Shackling*

42
43 Shackling refers to a form of restraint using a physical or mechanical device to control the
44 movement of an incarcerated individuals' body or limbs.³² It has been highlighted those conditions
45 in which the limitations are imposed by shackling, such as the increased risk of thrombosis from
46 reduced mobility, or related to the shackle itself could predispose patients to unnecessary harm.^{31,33}
47 In addition to physical harm or discomfort, one study demonstrated that patient shackling was
48 negatively associated with health care professional empathy toward patients who were
49 incarcerated.³⁴ In the United States, particular attention has been focused on the shackling of
50 incarcerated pregnant persons. The FIRST STEP Act of 2018 banned shackling of pregnant women
51 in federal custody from the date on which pregnancy is confirmed until their postpartum

1 recovery.³⁵ The majority of women, however, are incarcerated in state prisons.³⁶ Currently, 22
2 states and the District of Columbia prohibit or limit shackling of pregnant women. States vary in
3 legislation, with some banning shackles during transport, childbirth, and postpartum, whereas other
4 states ban shackles only during labor and birth.³⁷

5
6 Shackling policies for patients in custody should be differentiated from hospital restraint policies
7 for patients who are agitated or combative. Since shackles are often placed for nonmedical reasons,
8 the treating clinician should determine whether appropriate care can be delivered with shackles in
9 place.³⁸ Custody officials are then responsible for determining an alternative manner to safely
10 secure, or not secure, a patient who is incarcerated that allows for standards of medical care to be
11 met.

12 13 *Discharge Prescribing*

14
15 Physicians may also be concerned that medications prescribed on discharge will be misused by
16 patients in the correctional system, causing physicians to restrict or reconsider certain classes of
17 medication in the hospital or on discharge.³⁹ Commonly diverted medications in the correctional
18 setting include opioids, benzodiazepines, stimulants, antipsychotics, and γ -aminobutyric acid
19 agonists.⁴⁰ A study of incarcerated individuals found that 51.5 percent of participants reported
20 using illicit substances during incarceration, most commonly alcohol (35 percent) and cannabis
21 (37.9 percent), followed by narcotics (14.6 percent).⁴¹ A variety of psychotropic medications are
22 also misused in the correctional setting, although prescription medications lag behind more
23 common substances, such as alcohol and cannabis. Another study examining opioid agonist
24 therapies at a large jail, found that the medications for only 6 percent of patients were discontinued
25 during a month because of diversion concerns.⁴² Further, there is no evidence that rates of diversion
26 are increased among patients who are incarcerated relative to those in a community setting, and the
27 monitored correctional environment may provide a safer setting for medications with diversion
28 risk.⁴³

29 30 EXISTING AMA POLICY

31
32 AMA policy D-430.997 “Support for Health Care Services to Incarcerated Persons” supports
33 NCCHC standards that improve the quality of health care services, including mental health
34 services, delivered to the nation's correctional facilities; encourages all correctional systems to
35 support NCCHC accreditation; and encourages the NCCHC and its AMA representative to work
36 with departments of corrections and public officials to find cost effective and efficient methods to
37 increase correctional health services funding. This policy also calls on the AMA to work with an
38 accrediting organization, such as NCCHC in developing a strategy to accredit all correctional,
39 detention and juvenile facilities and will advocate that all correctional, detention and juvenile
40 facilities be accredited by the NCCHC no later than 2025.

41
42 AMA policy H-315.975 “Police, Payer, and Government Access to Patient Health Information”
43 advocates for protection of PHI but notably advocates “with respect to the final privacy rule or
44 other privacy legislation that no government agency, including law enforcement agencies, be
45 permitted access to medical records or individually identifiable health information (except for any
46 discretionary or mandatory disclosures made by physicians and other health care providers
47 pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without
48 the express written consent of the patient, or a court order or warrant permitting such access.”

49
50 Further, AMA policy H-430.980 “Compassionate Release for Incarcerated Patients” supports
51 policies that facilitate compassionate release for incarcerated patients based on serious medical

1 conditions and advanced age. The Board of Trustees previously presented a report to the House of
2 Delegates on compassionate release for incarcerated individuals.⁴⁴

3
4 CONCLUSION

5
6 The U.S. has the highest incarceration rate in the world. Compared to the general population,
7 individuals with a history of incarceration are in worse mental and physical health. Incarcerated
8 individuals typically have high rates of psychiatric conditions, communicable diseases, substance
9 use disorders, and chronic diseases. The U.S. Supreme Court has indicated that failure to provide
10 adequate medical care to incarcerated people as a result of deliberate indifference violates the
11 Eighth Amendment’s prohibition against cruel and unusual punishment. However, in practice,
12 federal courts have stated that to constitute “deliberate indifference,” treatment must be so grossly
13 incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to
14 fundamental fairness.

15
16 The principles of privacy and confidentiality apply to all patients, including those who are
17 incarcerated. HIPAA also equally applies to incarcerated individuals unless PHI disclosure is
18 necessary for the provision of health care or safety of the patient, or other individuals in the
19 facility.⁸ Hospital security policies may contravene this principle of confidentiality. The policy at
20 many institutions requires that officers be permitted to always remain with a patient in custody, and
21 although it is suggested that conversations be conducted out of hearing range, the officers must be
22 allowed to remain within direct sight of the patient.⁴⁵

23
24 Information on best practices and management of medical conditions among hospitalized patients
25 who are incarcerated or interact with law enforcement is limited and primarily focuses on the care
26 of pregnant individuals. NCCHC remains the only national organization dedicated solely to
27 improving correctional health care quality. This is done by establishing rigorous standards for
28 health services in correctional facilities, operating a voluntary accreditation program for institutions
29 that meet those standards, offering certification for correctional health professionals, conducting
30 educational conferences and webinars, and producing industry-specific publications and other
31 resources. AMA policy supports NCCHC standards. However, there is a need to incentivize
32 correctional facilities to pursue accreditation.

33
34 RECOMMENDATIONS

35
36 The Council on Science and Public Health recommends that the following be adopted, and the
37 remainder of the report be filed.

- 38
39 1. That our AMA amend policy D-430.993, “Study of Best Practices for Acute Care of
40 Patients in the Custody of Law Enforcement or Corrections” to read as follows:

41 ~~1. Our AMA will study best practices for interactions between hospitals, other acute~~
42 ~~care facilities, clinicians, and members of law enforcement or correctional agencies~~
43 ~~to ensure that patients in custody of such law enforcement or correctional agencies~~
44 ~~(including patients without decision-making capacity), their surrogates, and the~~
45 ~~clinicians caring for them are provided the autonomy and privacy protections~~
46 ~~afforded to them by law and in concordance with professional ethical standards~~
47 ~~and report its findings to the AMA House of Delegates by the 2023 Annual~~
48 ~~Meeting.~~

49
50 1. Our AMA supports the development of: (1) best practices for acute care of patients
51 in the custody of law enforcement or corrections, (2) clearly defined and consistently

- 1 implemented processes between health care professionals and law enforcement that (a)
2 can best protect patient confidentiality, privacy, and dignity while meeting the needs of
3 patients, health professionals, and law enforcement and (b) ensures security measures
4 do not interfere with the capacity to provide medical, mental health, pregnancy, end of
5 life/palliative, and substance use care, especially in emergency situations, and (3) a
6 hospital or health system-based health care professional and law enforcement liaison
7 team, that includes, but is not limited to, clinicians, members of the ethics committee,
8 hospital security, and legal services to serve as an immediate resource when questions
9 or conflicts arise. (Amend Current HOD Policy)
10
11 2. That our AMA affirms that: (1) the adoption of best practices in the acute care of patients
12 in the custody of law enforcement or corrections is an important effort in achieving overall
13 health equity for the U.S. as a whole, and (2) it is the responsibility of the medical staff to
14 ensure quality and safe delivery of care for incarcerated patients. (New HOD Policy)
15
16 3. That our AMA reaffirm Policy D-430.997 “Support for Health Care Services to
17 Incarcerated Persons” and Policy H-420.957 “Shackling of Pregnant Women in Labor.”
18 (Reaffirm HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 07 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse
and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 407-A-22, referred by the House of Delegates, asked our American Medical Association to study the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and study other validated, easily obtained alternatives to BMI for estimating risk of weight-related disease, and report its findings and report its findings to the AMA House of Delegates by the 2023 Annual Meeting. While this report was in development, the HOD also referred Resolution 937-I-22, “Indications for Metabolic and Bariatric Surgery” for consideration within this report. That resolution asked that our AMA acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “Body Mass Index (BMI),” “alternatives to BMI,” “BMI and Eating Disorders,” “Bariatric Surgery,” and “BMI AND culturally diverse.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. Body mass index (BMI) is easy to measure, is inexpensive, has standardized cutoff points for overweight and obesity, and is strongly correlated with body fat levels as measured by the most accurate methods. BMI is not a perfect measure, because it does not directly assess body fat. The current BMI classification system is also misleading regarding the effects of body fat mass on mortality rates. Numerous comorbidities, lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors, duration of time one spends in certain BMI categories, and the expected accumulation of fat with aging are likely to significantly affect interpretation of BMI data, particularly in regard to morbidity and mortality rates. Other methods to measure body fat are not always readily available, and they are either expensive or need to be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods. Further, the use of BMI is problematic when used to diagnose and treat individuals with eating disorders, because it does not capture the full range of abnormal eating disorders.

CONCLUSION. This report evaluates the problematic history of BMI and explores other alternatives to BMI. It outlines the harms and benefits to using BMI and points out that BMI is inaccurate in measuring body fat in multiple groups because it does not account for the heterogeneity across race/ethnic groups, sexes, and age-span. The recommendations recognize the issues with the use of BMI clinically, and highlights the need to use other methods. This report also acknowledges that AMA did not participate in the development of the “Indications for Metabolic and Bariatric Surgery” guidelines and therefore cannot endorse these guidelines.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 07-A-23

Subject: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 Resolution 407-A-22, referred by the House of Delegates (HOD), asked that our American Medical
2 Association (AMA):

3
4 recognize the significant limitations and potential harms associated with the widespread use of
5 body mass index (BMI) in clinical settings and supports its use only in a limited screening
6 capacity when used in conjunction with other more valid measures of health and wellness; and

7
8 support the use of validated, easily obtained alternatives to BMI (such as relative fat mass,
9 body adiposity index, and the body volume index) for estimating risk of weight-related disease;
10 and

11
12 amend policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and Waist
13 Circumference in the Diagnosis and Management of Adult Overweight and Obesity,” by
14 addition and deletion to read as follows:

15
16 The Clinical Utility of Measuring Body Mass Index Weight, Adiposity, and Waist
17 Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866
18 Our AMA supports:

19 (1) greater emphasis in physician educational programs on the risk differences ~~among ethnic~~
20 ~~and age within and between demographic groups~~ at varying weights and levels of adiposity
21 BMI and the importance of monitoring waist circumference in all individuals ~~with BMIs below~~
22 35 kg/m²;

23 (2) additional research on the efficacy of screening for overweight and obesity, using different
24 indicators, in improving various clinical outcomes across populations, including morbidity,
25 mortality, mental health, and prevention of further weight gain; and

26 (3) more research on the efficacy of screening and interventions by physicians to promote
27 healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their
28 patients to improve health and minimize disease risks. (Modify Current HOD Policy); and
29 amend policy H-150.965, by addition to read as follows in order to support increased
30 recognition of disordered eating behaviors in minority populations and culturally appropriate
31 interventions:

32
33 H-150.965 – Eating Disorders

34 The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to
35 one’s physical and mental health as obesity; (2) asks its members to help their patients avoid

1 obsessions with dieting and to develop balanced, individualized approaches to finding the body
2 weight that is best for each of them; (3) encourages training of all school-based physicians,
3 counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating,
4 dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate
5 referral of adolescents and their families for culturally-informed interventional counseling; and
6 (4) participates in this effort by consulting with appropriate and culturally informed educational
7 and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight
8 restrictive behaviors. (Modify Current HOD Policy)
9

10 While this report was in development, the HOD also referred Resolution 937-I-22, “Indications for
11 Metabolic and Bariatric Surgery” for consideration within this report. That resolution asked that
12 our AMA:

13
14 acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and
15 International Federation for the Surgery of Obesity and Metabolic Disorders indications for
16 metabolic and bariatric surgery; immediately call for full acceptance of these guidelines by
17 insurance providers, hospital systems, policy makers, and government healthcare delivery
18 entities; and work with all interested parties to lobby the legislative and executive branches of
19 government to affect public health insurance coverage to ensure alignment with these new
20 guidelines.

21 22 BACKGROUND

23
24 Body mass index (BMI) is the ratio of weight to height, calculated as weight (kg)/height (m²), or
25 weight (lb)/height (in²) multiplied by 703.¹ BMI is easy to measure, is inexpensive, has
26 standardized cutoff points for overweight and obesity, and is strongly correlated with body fat
27 levels as measured by the most accurate methods. However, BMI is an indirect and imperfect
28 measurement as it does not distinguish between body fat and lean body mass. It is not as accurate
29 of a predictor of body fat in the elderly and at the same BMI women on average have more body
30 fat than men and Asians have more body fat than whites.¹ Further, when combined with measuring
31 waist circumference, patients may be screened for possible health risks that come with being
32 overweight and having obesity. If most of the fat is around the waist rather than at the hips, an
33 individual is at a higher risk for heart disease and type 2 diabetes.¹ This risk goes up with a waist
34 size that is greater than 35 inches for women or greater than 40 inches for men.
35

36 BMI is used because it is an inexpensive and easy tool. Research has shown that BMI is strongly
37 correlated with the gold-standard method for measuring body fat known as dual-energy x-ray
38 absorptiometry (DXA), and it is an easy way for clinicians to screen who might be at greater risk of
39 health problems due to their weight.² Other methods to measure body fat include skinfold thickness
40 measurements (with calipers), underwater weighing, bioelectrical impedance, and isotope dilution.²
41 However, these methods are not always readily available, and they are either expensive or need to
42 be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to
43 standardize across observers or machines, complicating comparisons across studies and time
44 periods.
45

46 BMI is just one of several considerations to help determine a more specific and individualized
47 course of action for patients. Some researchers are advocating for a new kind of classification
48 system based on the concept of Adiposity-Based Chronic Disease (ABCD) — focusing more on
49 the health issues associated with obesity rather than body size alone.³ The diagnostic term reflects
50 both the pathophysiology and clinical impact of obesity as a chronic disease. The proposed coding
51 system has four domains: pathophysiology, body mass index (BMI) classification, complications,

1 and complication severity; and incorporates disease staging, specific complications that impact
2 health, the basis for clinical intervention, individualized treatment goals and a personalized
3 medicine approach.

4 5 METHODS

6
7 English language articles were selected from searches of PubMed and Google Scholar using the
8 search terms “Body Mass Index (BMI),” “alternatives to BMI,” “BMI and Eating Disorders,”
9 “Bariatric Surgery,” and “BMI AND culturally diverse.” Additional articles were identified by
10 manual review of the reference lists of pertinent publications. Web sites managed by government
11 agencies; applicable organizations were also reviewed for relevant information.

12 13 DISCUSSION

14 15 *Prevalence of obesity in the U.S.*

16
17 In 2021, the CDC Adult Obesity Prevalence Map shows that obesity remains high. Nineteen states
18 and two territories currently have an obesity prevalence at or above 35 percent, more than doubling
19 from 2018.⁴ Adults with obesity are at increased risk for many other serious health conditions such
20 as heart disease, stroke, type 2 diabetes, some cancers, and poorer mental health. Obesity also
21 disproportionately impacts some racial and ethnic minority groups.⁴ Non-Hispanic Black adults
22 had the highest prevalence of self-reported obesity (41.7 percent), followed by non-Hispanic
23 American Indian or Alaska Native adults (38.4 percent), Hispanic adults (36.1 percent), non-
24 Hispanic White adults (31.0 percent), and non-Hispanic Asian adults (11.7 percent).⁴

25
26 Childhood obesity is a serious problem in the United States that puts children and adolescents at
27 risk for poor health outcomes. From 2017-2020, the prevalence of obesity was 19.7 percent and
28 affected about 14.7 million children and adolescents.⁵ Obesity prevalence was 12.7 percent among
29 2- to 5-year-olds, 20.7 percent among 6- to 11-year-olds, and 22.2 percent among 12- to 19-year-
30 olds. Obesity prevalence was 26.2 percent among Hispanic children, 24.8 percent among non-
31 Hispanic Black children, 16.6 percent among non-Hispanic White children, and 9.0 percent among
32 non-Hispanic Asian children.⁵ Obesity-related conditions include high blood pressure, high
33 cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint
34 problems.⁵

35 36 *History of measures to calculate body weight (Body Build Index)*

37
38 The concept of body fat as a major population-based medical issue gained popularity only shortly
39 before 1900. Life insurance data accumulated at that time and subsequently indicated that body
40 weight, adjusted for height (Wt/Ht), was an independent determinant of life expectancy, and in
41 1910, the effects of being overweight were noted to be greater for younger people than for the
42 elderly.⁶ The Metropolitan Life Insurance Company in 1959 published tables of average body
43 weights for heights (Wt/Ht), also known as body build, by gender and at different ages.⁷ This was
44 based on data from 1935 to 1953 from more than 4 million adults, mostly men, insured by 26
45 different insurance companies. The risk for development of certain diseases as well as mortality
46 data related to Wt/Ht differences also were analyzed and reported in the 1960 Statistical Bulletin of
47 the Metropolitan Life Insurance Co.⁸

48
49 The Wt/Ht tables were used for many years as a reference for population-based studies. If a
50 person’s Wt/Ht was 20 percent above or below the mean for that height category, they were
51 considered to be overweight or underweight, respectively.¹⁴ The insurance data also indicated the

1 ratios of weights for heights at which mortality was lowest in adults. The latter was referred to as
2 the “ideal” or later the “desirable” weight. From 1959 to 1983, the weight/height representing the
3 lowest mortality had increased.^{9,10} However, a “desirable body” weight for height was invariably
4 lower than the average weight for height in the insured population.^{15,16}

5 6 *Challenges with the wt/ht (body build) index*

7
8 Early on it was recognized that taller people had a lower death rate than shorter people with the
9 same Wt/Ht ratio.¹¹ It also was recognized that a person’s height in general and leg length could
10 affect the calculated body mass adjusted for height. A person’s bone mass could also affect the
11 interpretation of this ratio. In general, it reflected whether one was narrowly or broadly built. Thus,
12 efforts were made to eliminate lower limb length and frame size as variables.¹³ The strategy was to
13 develop representations of body build, that is, charts of weight/height that were independent of
14 these variables. The overall goal was to have the same distribution of Wt/Ht at each level of height.

15
16 Although not stated, the implicit goal in developing these tables was to define a person’s fat mass
17 as a proportion of their total mass, irrespective of their height or frame size.¹² Efforts were made to
18 adjust for frame size (nonfat mass) by categorizing people as those with a small, medium, or large
19 frame. Estimation of frame size was attempted using several measurements including shoulder
20 width, elbow width, knee width, ankle width, and so on.¹³ None of these were widely adopted.
21 Further, frame size based on elbow width was included in the Metropolitan Life weight/height
22 tables, even though it was never validated.¹³

23 24 *Adoption of the BMI as an index of obesity*

25
26 In 1972, the validity of Metropolitan Life Insurance published data was criticized.¹⁴ Critics
27 supported the use of the better documented weight for height data, which then popularized what is
28 known as the Quetelet Index. The Quetelet Index was later known as an individual’s body mass
29 index (BMI). However, it was noted that even BMI rather poorly represents a person’s percent of
30 body fat.²⁰ Despite all the criticisms, the Metropolitan Life Tables criteria for defining obesity were
31 widely used in the United States until the early 1990s.^{15,16} At about that time, the World Health
32 Organization (WHO) classification of body weight for height, based on the BMI, was published,
33 and later it was widely adopted.^{17,18} The distribution of BMIs in adult American men and women
34 was determined in 1923 in 1026 individuals.¹⁹ The median BMI was 24, but the mean BMI was 25.
35 The distribution curve indicated a skewing toward an increase in BMI, and this trend has
36 continued.²⁴

37 38 *WHO and the categorization of BMIs into quartiles*

39
40 In 1993, the WHO assembled an Expert Consultation Group with a charge of developing uniform
41 categories of the BMI. The results were published as a technical report in 1995.²⁰ Four categories
42 were established: underweight, normal, overweight, and obese. An individual would be considered
43 underweight if their BMI was in the range of 15 to 19.9, normal weight if the BMI was 20 to 24.9,
44 overweight if the BMI was 25 to 29.9, and obese if it was 30 to 35 or greater.²⁶

45
46 At the time that the WHO classification was published, the National Institutes of Health (NIH) in
47 the United States classified people with a BMI of 27.8 (men) and 27.3 (women) or greater as being
48 overweight. If they were below this BMI, they were considered to be “normal.” This was based on
49 an 85 percent cutoff point of people examined in the National Health and Nutrition Examination
50 Study (NHANES) II.²¹ Subsequently, in 1998, the cutoff point between normal and overweight was
51 reduced to a BMI of 25 to bring it into line with the 4 categories in the WHO guidelines.²² This

1 then changed the categorization of millions of Americans from being “normal weight” to being
2 “overweight.”

3
4 In Western population-based studies, the mean or median BMI was about 24 to 27.^{23,24} Therefore,
5 the consequence of adopting the WHO classification resulted in approximately 50 percent or more
6 of the general adult population being classified as overweight and obese. Indeed, the term
7 “overweight” or particularly “preobesity” is prejudicial since people in this category were a major
8 part of the expected normal distribution of BMI in the general population.

9 10 *Advantages of BMI*

11
12 A significant advantage of BMI is the availability of extensive national reference data and its
13 established relationships with levels of body fatness, morbidity, and mortality in adults.²⁶ BMI is
14 particularly useful in monitoring the treatment of obesity, with a weight change of about 3.5 kg
15 needed to produce a unit change in BMI. In adults, BMI levels above 25 are associated with an
16 increased risk of morbidity and mortality, with BMI levels of 30 and greater indicating obesity.²⁵ In
17 children, BMI is not a straightforward index because of growth. However, high BMI percentile
18 levels based on Centers for Disease Control and Prevention (CDC) BMI growth charts and changes
19 in parameters of BMI curves in children are linked to significant levels of risk for adult obesity at
20 corresponding high percentile levels.²⁶ Further, BMI is readily available, inexpensive, can be
21 administered easily, and is understood easily by patients.²⁷ BMI can also be used as an initial
22 screening tool to identify those at an elevated health risk because of excess body weight and poor
23 distribution of fat mass.

24 25 *Disadvantages of BMI*

26
27 BMI as a determinant of body fat mass. BMI does not differentiate between body lean mass and
28 body fat mass; a person can have a high BMI but still have a very low-fat mass and vice versa.^{28,29}
29 From an anatomical and metabolic perspective, it has been proposed that the term obesity should
30 refer to an excessive accumulation of body fat (triacylglycerols). The accuracy of the BMI as a
31 determinant of body fat mass has been repeatedly questioned because it has limitations in this
32 regard.^{30,31} Gender, age, ethnicity, and leg length are important variables not considered by
33 BMI.^{32,33} It should also be noted that in population-based studies women generally have a BMI that
34 is lower than that in men, even though their fat mass relative to their body build or BMI is
35 considerably greater.

36
37 The relatively poor correlation between percent of body fat mass and BMI has been shown more
38 recently in the NHANES III database in which bioelectrical impedance was used to estimate the fat
39 component of body composition.³⁹ In subjects with a BMI of 25 kg/m², the percent of body fat in
40 men varied between 14 percent and 35 percent, and in women it varied between 26 percent and 43
41 percent. Therefore, using the NIH criteria based on percent of body fat to define obesity, subjects
42 with a BMI of 25, a group that would be considered “normal,” were associated with a body fat
43 mass that varied between “low normal” to “obese.”

44
45 In addition, a recent study in individuals with or without diabetes in which the loss of lean body
46 mass with aging was reported, the mean BMI in those without diabetes was 26.8. In those with
47 diabetes, the BMI was 29.1. However, the percent of lean body mass was the same and therefore
48 the increased BMI in those with diabetes was not due only to an excessive accumulation of fat.³⁴
49 Overall, although the correlation between the BMI and body fatness is strong, two people might
50 have the same BMI, but the level of body fatness may differ.³⁵ Some examples of this include:

- 51 • Women tend to have more body fat than men,

- 1 • The amount of body fat may be higher or lower depending on the racial/ethnic group,³⁶
- 2 • Older people, on average, tend to have more body fat than younger adults, and
- 3 • Athletes have less body fat than do non-athletes.

4
 5 BMI does not account for body fat location. BMI does not capture body fat location information,
 6 which is an important variable in assessing the metabolic as well as mortality consequences of
 7 excessive fat accumulation. This was first recognized in France by Dr Jon Vague in the 1940-
 8 1950s.³⁷ He noted that accumulation of fat in the upper part of the body versus the lower part of the
 9 body was associated with an increased risk for coronary heart disease, diabetes, and also gallstones
 10 and gout. Men tend to accumulate fat in the abdominal (upper body) area, whereas women tend to
 11 accumulate it in the peripelvic (gluteal) area and the thighs. A substitute for this information has
 12 been to determine the abdominal circumference or an abdominal/hip circumference ratio.
 13 Subsequent data indicate that the risk for development of diabetes as well as coronary heart
 14 disease, is more strongly related to the accumulation of upper body fat than lower body fat in both
 15 sexes.³⁸

16
 17 More specifically, both visceral fat accumulation and an expanded girth have been associated with
 18 development of insulin resistance, diabetes, and risk for coronary heart disease and hypertension.³⁹
 19 Accumulation of fat in the abdominal area appears to correlate best with triacylglycerols
 20 accumulating in the liver and skeletal muscle. Further, the relatively small accumulation of fat in
 21 these organs would not be detectible by BMI determinations, and they do not correlate with total
 22 body fat mass.⁴⁰

23
 24 BMI does not account for the life cycle and location of accumulated fat caused by hormones. Girls
 25 tend to accumulate relatively large amounts of fat during and after puberty, particularly in the
 26 peripelvic and thigh region; boys do not. During and after puberty, boys accumulate a relatively
 27 large amount of lean mass (bone and muscle) but not fat mass. In both sexes, these changes are
 28 reflected in an increased BMI. With aging, both sexes tend to develop fat in the upper part of the
 29 body.⁴¹ The reason for these changes in amount and distribution is not completely understood.
 30 Generally, it is considered to be caused by hormonal changes. Further, a study noted BMI cutoffs
 31 fail to capture most postmenopausal women whose actual body fat percentage would classify them
 32 as obese.⁴² As women age, they tend to lose bone and muscle mass, which are heavier than fat. So
 33 even if a 65-year-old woman weighs the same as she did at 25 years of age, fat accounts for a larger
 34 share of her weight. The study suggested that to improve the sensitivity of BMI in identifying
 35 postmenopausal women at risk of obesity-related diseases, the obesity cutoff might need to be set
 36 to 24.9, which is currently the top of the normal BMI range for the general adult population.⁴²

37
 38 BMI as a predictor of morbidity and mortality. The BMI classification system currently is being
 39 widely used in population-based studies to assess the risk for mortality in the different categories of
 40 BMI. Even when some comorbidities are considered, the correlation of mortality rates with BMI
 41 often does not take into consideration such factors as family history of diabetes, hypertension,
 42 coronary heart disease, metabolic syndrome, dyslipidemias, familial longevity or the family
 43 prevalence of carcinomas, and other genetic factors. For example, it has been reported that more
 44 than 50 percent of susceptibility to coronary artery disease is accounted for by genetic variants.⁴³

45
 46 Frequently, when correlations are made, they also do not take into consideration a past as well as a
 47 current history of smoking, excessive alcohol use, serious and persistent mental illness or the
 48 duration of obesity, when in the life cycle it appeared, and whether the body weight is relatively
 49 stable or rapidly progressive. In most population-based studies, only the initial weight and/or BMI
 50 are given, even though weight as well as fat stores are known to increase and height to decrease
 51 with aging. In addition, the rate of weight gain varies among individuals, as does the loss of muscle

1 mass.⁴⁴ Muscle mass has been correlated negatively with insulin resistance and prediabetes.⁴⁵
2 Lastly, population-based studies do not take into consideration the present and past history of a
3 person's occupation, medication-induced obesity, and how comorbidities are being treated.
4

5 BMI does not appropriately represent racial and ethnic minorities. The rise in obesity prevalence
6 rates has disproportionately affected U.S. minority populations. For example, one longitudinal
7 study of healthy women found that at the same BMI, Asians had more than double the risk of
8 developing type 2 diabetes than whites; Hispanics and blacks also had higher risks of diabetes than
9 whites, but to a lesser degree.⁴⁶ Increases in weight over time were more harmful in Asians than in
10 the other ethnic groups: For every 11 pounds Asians gained during adulthood, they had an 84
11 percent increase in their risk of type 2 diabetes; Hispanics, blacks, and whites who gained weight
12 also had higher diabetes risks, but again, to a much lesser degree than Asians.⁴⁶ Several other
13 studies have found that at the same BMI, Asians have higher risks of hypertension and
14 cardiovascular disease than their white European counterparts, and a higher risk of dying early
15 from cardiovascular disease or any cause.^{47,48}
16

17 Researchers are still assessing why Asians have higher weight-related disease risks at lower BMIs.
18 One possible explanation is body fat. When compared to white Europeans of the same BMI, Asians
19 have 3 to 5 percent higher total body fat.⁴⁹ South Asians, in particular, have especially high levels
20 of body fat and are more prone to developing abdominal obesity, which may account for their very
21 high risk of type 2 diabetes and cardiovascular disease.⁵⁰ In contrast, some studies have found that
22 blacks have lower body fat and higher lean muscle mass than whites at the same BMI, and
23 therefore, at the same BMI, may be at lower risk of obesity-related diseases.⁵¹ While genetic
24 differences may be at the root of these different body fat patterns in Asians and other ethnic groups,
25 environmental factors seem to be a much stronger force. For example, research suggests that under-
26 nutrition during fetal life, such as during the Chinese famine of 1954 to 1964, raises the risk of
27 diabetes in adulthood, especially when individuals live in nutritionally rich environments later in
28 life.⁵²
29

30 BMI AND EATING DISORDERS

31

32 Eating disorders are behavioral conditions characterized by severe and persistent disturbance in
33 eating behaviors and associated distressing thoughts and emotion. Types of eating disorders include
34 anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder,
35 other specified feeding and eating disorders, pica and rumination disorder. Eating disorders affect
36 up to 5 percent of the population, and most often develop in adolescence and young adulthood.⁵³
37 Evidence suggests that genes and heritability also play a part in why some people are at higher risk
38 for an eating disorder.⁵³
39

40 Anorexia nervosa is an eating disorder characterized by self-starvation and weight loss resulting in
41 low weight for height and age.⁵³ BMI is used to diagnose an individual with anorexia nervosa and
42 is determined by an individual having a BMI of 18.5 or less.⁵³ Although BMI is used to diagnose
43 anorexia nervosa, BMI does not accurately capture individuals with bulimia nervosa. Individuals
44 with bulimia nervosa can be slightly underweight, normal weight, overweight or even obese.⁵³
45 Further, BMI is inaccurate in capturing individuals with other specified feeding and eating
46 disorders. These include eating disorders or disturbances of eating behavior that cause distress and
47 impair family, social or work function but do not fit the other categories. In some cases, this is
48 because the frequency of the behavior does not meet the diagnostic threshold (i.e., the frequency of
49 binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia
50 nervosa are not met.⁵³ An example of another specified feeding and eating disorder is "atypical
51 anorexia nervosa". This category includes individuals who may have lost a lot of weight and whose

1 behaviors and preoccupation with weight or shape concerns and fear of fatness is consistent with
2 anorexia nervosa, but who are not yet considered underweight based on their BMI because their
3 baseline weight was above average.⁵³ Therefore, utilizing BMI can lead to substandard treatment,
4 typically due to the use of BMI by insurance companies to cover inpatient treatment.⁵⁴ Further, as
5 mentioned above, BMI is an inaccurate measure of obesity especially in children and adolescents
6 and can therefore hinder access to eating disorder treatments.⁴¹

8 OTHER DIAGNOSTIC MEASURES FOR DIAGNOSING OBESITY

10 *Abdominal Circumference*

12 Obesity is commonly associated with increased amounts of intra-abdominal fat. A centralized fat
13 pattern is associated with the deposition of both intra-abdominal and subcutaneous abdominal
14 adipose tissue.⁵⁵ It should be noted that abdominal circumference is an imperfect indicator of intra-
15 abdominal adipose tissue, as it also includes subcutaneous fat deposition, as well as visceral
16 adipose tissue. This does not preclude its usefulness, as it is associated with specific health risks.⁵⁶
17 Persons in the upper percentiles for abdominal circumference are considered to have obesity and at
18 increased risk for morbidity, specifically type 2 diabetes and the metabolic syndrome, and
19 mortality.⁵⁷ The ratio of abdominal circumference (often referred to incorrectly as “waist”
20 circumference) to hip circumference is a rudimentary index for describing adipose tissue
21 distribution or fat patterning.⁵⁸ Abdomen-to-hip ratios greater than 0.85 represent a centralized
22 distribution of fat. Most men with a ratio greater than 1.0 and women with a ratio greater than 0.85
23 are at increased risk for cardiovascular disease, diabetes, and cancers.⁵⁹

25 *Skinfold Measurement*

27 Skinfold measurements are used to characterize subcutaneous fat thickness at various regions of the
28 body, but it should be noted that they have limited utility in people who are considered overweight
29 or have obesity. The primary limitation is that most skinfold calipers have an upper measurement
30 limit of 45 to 55 mm, which restricts their use to subjects who are moderately overweight or
31 thinner.² A few skinfold calipers take large measurements, but this is not a significant improvement
32 because of the difficulty of grasping and holding a large skinfold while reading the caliper dial. The
33 majority of national reference data available are for skinfolds at the triceps and subscapular
34 locations. The triceps skinfold varies considerably by sex and can reflect changes in the underlying
35 triceps muscle rather than an actual change in body fatness. The statistical relationships between
36 skinfolds and percent or total body fat in children and adults are often not as strong as that of
37 BMI.⁶⁰ Further, the upper distribution of subcutaneous fat measurements remains unknown because
38 most children and adults who have obesity have not had their skinfolds measured.

40 *Waist-to-hip Ratio*

42 The waist-to-hip ratio is often considered a better measurement than waist circumference alone in
43 predicting disease risk. To calculate the waist-to-hip ratio, a measuring tape is used to measure
44 waist circumference and hip circumference at its widest part. Observational studies have
45 demonstrated that people with “apple-shaped” bodies, (who carry more weight around the waist)
46 have greater risks for chronic disease than those with “pear-shaped” bodies, (who carry more
47 weight around the hips). A study with more than twenty-seven thousand participants from fifty-two
48 countries concluded that the waist-to-hip ratio is highly correlated with heart attack risk worldwide
49 and is a better predictor of heart attacks than BMI.⁶¹ Abdominal obesity is defined by the World
50 Health Organization (WHO) as having a waist-to-hip ratio above 0.90 for males and above 0.85 for
51 females.

1 *Visceral Adiposity Index (VAI)*

2
3 The Visceral Adiposity Index (VAI) is an empirical-mathematical model, gender-specific, based on
4 simple anthropometric (BMI and WC) and functional parameters (triglycerides (TG) and HDL
5 cholesterol (HDL)), and indicative of fat distribution and function.⁶² It is an empirical-
6 mathematical model that does not originate from theoretical assumptions, but from observation in a
7 healthy normal/overweight population of a linear relationship between BMI and CV, from which a
8 linear equation has been extrapolated. The main strength to consider is that the VAI is an indicator
9 of early cardiometabolic risk in all borderline conditions in which overt metabolic syndrome is not
10 present. This is explained by the fact that three of the variables making up the VAI (WC, TG, and
11 HDL) are all expressed in the criteria for metabolic syndrome. An important limitation to consider
12 is the application of the VAI in non-Caucasian populations and in patients aged less than 16
13 years.⁵⁸ This is because the mathematical modelling process was done on healthy Caucasian men
14 and women, aged between 19 and 83 years.⁵⁸ A study which evaluated the VAI in children, found
15 that the VAI should be extrapolated with caution in this age range.⁶³ Therefore, VAI is a useful
16 measurement in the following populations: healthy or apparently healthy population with BMI <
17 40 kg/m², patients with one or two of the 5 components of the metabolic syndrome, women with
18 PCOS, and patients with endocrine disorders (i.e., acromegaly, adult GH deficiency,
19 hypogonadism, hyperprolactinemia, or abnormal thyroid function).⁵⁸

20
21 *Relative Fat Mass (RFM)*

22
23 Relative fat mass (RFM) is a simple linear equation based on height-to-waist ratio, and has promise
24 as a potential alternative tool to estimate whole-body fat percentage in women and men 20
25 years of age and older. One study performed using nationally representative samples of the US
26 adult population which allowed evaluation of the performance of RFM among Mexican Americans,
27 European Americans, and African Americans.⁶⁴ The performance of RFM to estimate body fat
28 percentage was overall more consistent than that of BMI among women and men, across ethnic
29 groups, young, middle-age and older adults, and across quintiles of body fat percentage, although
30 the accuracy of RFM was lower among individuals with lower body fatness.⁶⁰

31
32 *Hydrostatic weighing (densitometry)*

33
34 Hydrostatic weighing (underwater weighing), or densitometry, is the difference of the body weight
35 in air and water is used to compute the body's density.⁶⁵ Assuming a two-component model with
36 different densities for fat mass and fat-free mass and correcting for the air volume in the lungs, the
37 total body fat percentage can be estimated. This technique, however, cannot give any
38 measurements of the distribution of adipose tissue or lean tissue (LT).

39
40 *Air displacement plethysmography (ADP)*

41
42 ADP, also known under its commercial brand name as BOD POD, measures the overall body
43 density, total body fat and lean tissue but not their distributions.⁶⁶ By putting the body in an
44 enclosed chamber and changing the chamber's volume, the volume of the displaced air (i.e., the
45 volume of the body) can be determined from the changes in air pressure.⁶⁰ Since ADP is based on
46 the same two-component model as hydrostatic weighing, it is also affected by the same
47 confounders, mainly variations in bone mineral content and hydration. Therefore, ADP, as well as
48 hydrostatic weighing, is limited to gross body composition analysis, and not estimates of regional
49 fat or muscles.

50
51 *Bioelectrical impedance analysis (BIA)*

1
2 BIA uses the electrical properties of the body to estimate the total body weight and from that the
3 body fat mass.⁶⁷ The body is modeled as five cylindrical lean tissue compartments; the trunk and
4 the four limbs, while fat is considered to be an insulator. The impedance is assumed to be
5 proportional to the height and inversely proportional to the cross-sectional area of each
6 compartment. BIA requires different model parameters to be used depending on age, gender, level
7 of physical activity, amount of body fat, and ethnicity in order to be reliable.⁶⁸

8 9 *Dual-energy X-ray absorptiometry (DXA)*

10
11 DXA is a two-dimensional imaging technique that uses X-rays with two different energies. By
12 using two different energy levels, the images can be separated into two components (i.e., bone and
13 soft tissue). DXA is mainly used for bone mineral density measurements, where it is considered as
14 the gold standard, but it can also be used to estimate total and regional body fat and lean tissue
15 mass.⁶⁹ DXA has been found to be more accurate than density- based methods for estimating total
16 body fat.⁷⁰ Due to its ability to estimate regional fat and measure lean tissue, in combination with
17 relatively high availability, DXA has been used for body composition analysis in a wide range of
18 clinical applications and is considered the gold standard for measuring body fat.⁷¹

19 20 *Computed Tomography (CT) Scan*

21
22 CT gives a three-dimensional high-resolution image volume of the complete or selected parts of the
23 body, computed from a large number of X-ray projections of the body from different angles. As
24 opposed to the previously described techniques, CT can accurately determine fat in skeletal muscle
25 tissue and in the liver.⁷² In practice, however, CT-based body composition analysis is in most cases
26 limited to two-dimensional analysis of one or a limited number of axial slices of the body. This
27 approach, however, limits its precision since the exact locations of slices, in relation to internal
28 organs, cannot be determined and will vary between scans. Regardless, CT, together with MRI, is
29 today considered the gold standard for body composition analysis, which assessed the proportion of
30 fat to fat-free mass in your body.

31 32 *Magnetic resonance imaging (MRI)*

33
34 MRI uses the different magnetic properties of the nuclei of certain chemical elements (normally
35 hydrogen in water and fat) in the cells to produce images of soft tissue in the body. Several MRI-
36 based methods for quantification of adipose tissue and muscles have been developed and
37 implemented.⁷³ MRI is used to obtain precise measurements of regional adipose tissue and lean
38 tissue, as well as diffuse fat infiltration in other organs. However, due to several undeterminable
39 factors affecting the MR signal, an MR image is not calibrated on an absolute scale and therefore
40 cannot be quantitative. But by using different postprocessing techniques, the image can be
41 calibrated to quantitatively measure fat or adipose tissue.⁶⁹

42 43 CALCULATING OBESITY IN CHILDREN AND ADOLESCENTS

44
45 In the United States, obesity and severe obesity in children and adolescents are defined using
46 threshold values from the 2000 CDC sex-specific body mass index-for-age growth charts.⁷⁴ In
47 addition to defining obesity, BMI z-scores and percentiles are used to monitor children's weight
48 status over time and to evaluate obesity treatments in research settings. Percentiles near the upper
49 limit of 100 percent become less useful for detecting meaningful differences, and therefore
50 percentiles can be converted to z-scores that indicate the number of standard deviations of a value
51 from the mean. However, BMI z-scores (BMIZ) and percentiles based on the 2000 BMI-for-age

1 CDC growth charts (BMIz and BMI percentiles) were never meant to be used to monitor children
 2 with extremely high BMI values, and significant limitations exist when they are used to monitor
 3 children with severe obesity.⁷⁵ Specifically, BMIz values corresponding to extremely high BMI
 4 values are compressed into a very narrow range. Studies on obesity prevalence, its impact, and the
 5 availability of effective treatment have highlighted the need for meaningful standardized measures
 6 to track extremely high values of BMI in clinical and research settings.

7
 8 As a result of needing more standardized measures the CDC studied alternative BMI metrics which
 9 include:

- 10 • BMI (untransformed),
- 11 • BMI z-scores and percentiles (modified),
- 12 • BMI z-scores and percentiles (extended),
- 13 • Percent of 95th percentile BMI units or percent from median, and
- 14 • Adjusted BMI units or percent from median.⁷⁶

15
 16 None of these metrics had the problem of compression at extremely high BMI values, but all had
 17 limitations, especially when applied across the weight status spectrum and a wide range of ages.
 18 The report however concluded that the extended method for calculating z-scores and percentiles
 19 stands out among the alternatives.⁷² First, the extended method improves the characterization of
 20 BMI distributions at very high values using nationally representative data, but all other BMI
 21 metrics that refer to a reference population (all alternative metrics except untransformed BMI) rely
 22 on extrapolating beyond this reference population.⁷² Second, below the 95th percentile, extended
 23 BMI z-scores and percentiles preserve CDC 2000 z-scores and percentiles that are currently in use,
 24 which allows seamless transitions from the current CDC z-scores and percentiles below the 95th
 25 percentile to extended z-scores and percentiles above the 95th percentile.⁷² Alternative BMI metrics
 26 other than extended BMIz and percentiles may be appropriate for use in certain scenarios, such as
 27 during adolescence when differences among the metrics are less pronounced, when transitions to or
 28 from obesity are minimal, or for monitoring BMI changes over short periods when adjusting for
 29 expected growth and development is less critical.

30
 31 **INDICATIONS FOR METABOLIC AND BARIATRIC SURGERY**

32
 33 During the HOD Interim meeting in 2022, Resolution 937 “Indications for Metabolic and Bariatric
 34 Surgery,” was introduced by the American Society for Metabolic and Bariatric Surgery, Society of
 35 American Gastrointestinal and Endoscopic Surgeons . This resolution called for adoption of the
 36 new American Society for Metabolic and Bariatric Surgery and International Federation for the
 37 Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery. Given
 38 that these guidelines depend on BMI, they were referred for consideration in this report.

39
 40 The American Society for Metabolic and Bariatric Surgery (ASMBS) and the International
 41 Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) have convened to produce a
 42 joint statement on the current available scientific information on metabolic and bariatric surgery
 43 and its indications recommending the following updates:

- 44 • Metabolic and bariatric surgery (MBS) is recommended for individuals with a body mass
 45 index (BMI) ≥ 35 kg/m², regardless of presence, absence, or severity of co-morbidities.
- 46 • MBS should be considered for individuals with metabolic disease and BMI of 30-34.9
 47 kg/m².
- 48 • BMI thresholds should be adjusted in the Asian population such that a BMI ≥ 25
 49 kg/m² suggests clinical obesity, and individuals with BMI ≥ 27.5 kg/m² should be offered
 50 MBS.

- 1 • Long-term results of MBS consistently demonstrate safety and efficacy.
- 2 • Appropriately selected children and adolescents should be considered for MBS.⁷⁷

3
4 It should be noted that the AMA did not participate in the development of these guidelines and
5 therefore cannot endorse these guidelines. AMA policies are also adopted for a period of 10 years
6 with the option of renewal through the Sunset process, therefore it is important to not reference
7 specific guidelines in policy which may change over time.

8 9 EXISTING AMA POLICY

10
11 Under existing AMA Policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and
12 Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity” the
13 AMA supports: (1) greater emphasis in physician educational programs on the risk differences
14 among ethnic and age groups at varying levels of BMI and the importance of monitoring waist
15 circumference in individuals with BMIs below 35 kg/m²; (2) additional research on the efficacy of
16 screening for overweight and obesity, using different indicators, in improving various clinical
17 outcomes across populations, including morbidity, mortality, mental health, and prevention of
18 further weight gain; and (3) more research on the efficacy of screening and interventions by
19 physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical
20 activity, in all of their patients to improve health and minimize disease risks.

21
22 Policy H-150.928, “Eating Disorders and Promotion of Healthy Body Image,” supports increased
23 funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment
24 of eating disorders, including research on the effectiveness of school-based primary prevention
25 programs for pre-adolescent children and their parents, in order to prevent the onset
26 of eating disorders and other behaviors associated with a negative body image.

27
28 Policy H-150.965, “Eating Disorders” notes that the AMA (1) adopts the position that
29 overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity;
30 (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced,
31 individualized approaches to finding the body weight that is best for each of them; (3) encourages
32 training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to
33 recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer
34 education and appropriate referral of adolescents and their families for interventional counseling;
35 and (4) participates in this effort by consulting with appropriate specialty societies and by assisting
36 in the dissemination of appropriate educational and counseling materials pertaining to unhealthy
37 eating, dieting, and weight restrictive behaviors.

38 39 CONCLUSIONS

40
41 The most basic definition of obesity is having too much body fat, so much so that it presents a risk
42 to health.⁷⁸ A reliable way to determine whether a person has too much body fat is to calculate the
43 ratio of their weight to their height squared. This ratio, called the body mass index (BMI), accounts
44 for the fact that taller people have more tissue than shorter people, and so they tend to weigh more.
45 BMI is not a perfect measure, because it does not directly assess body fat. Muscle and bone are
46 denser than fat, so an athlete or muscular person may have a high BMI, yet not have too much fat.
47 Risk of developing health problems, including several chronic diseases such as heart disease and
48 diabetes, rises progressively for BMIs above 21. There's also evidence that at a given BMI, the risk
49 of disease is higher in some ethnic groups than others.

1 Critics of BMI note that body fat location is also important and could be a better indicator of
2 disease risk than the amount body fat.⁷⁹ Fat that accumulates around the waist and chest (what is
3 called abdominal adiposity) may be more dangerous for long-term health than fat that accumulates
4 around the hips and thighs. Some researchers have further argued that BMI should be discarded in
5 favor of measures such as waist circumference.⁷⁵ However, this is unlikely to happen given that
6 BMI is easier to measure and has a long history of use. In adults, measuring both BMI and waist
7 circumference may be a better way to predict someone's weight-related risk. In children, however,
8 there is no good reference data for waist circumference, so BMI-for-age is currently the gold
9 standard. Overall, BMI does not describe body fat distribution, so additional anthropometric
10 parameters should be used to assess enhanced accumulation of visceral adipose tissue.

11
12 Further, the current BMI classification system is misleading regarding the effects of body fat mass
13 on mortality rates. The role of fat distribution in the prediction of medically significant morbidities
14 as well as for mortality risk is not captured by use of the BMI. Also, numerous comorbidities,
15 lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors,
16 duration of time one spends in certain BMI categories, and the expected accumulation of fat with
17 aging are likely to significantly affect interpretation of BMI data, particularly in regard to
18 morbidity and mortality rates. Such confounders as well as the known clustering of obesity in
19 families, the strong role of genetic factors in the development of obesity, the location in which
20 excessive fat accumulates, its role in the development of type 2 diabetes and hypertension, and so
21 on, need to be considered before promulgation of public health policies that are designed to apply
22 to the general population and are based on BMI data alone. Further, the use of BMI is problematic
23 when used to diagnose and treat individuals with eating disorders, because it does not capture the
24 full range of abnormal eating disorders. It should also be noted that the recent increase in fat
25 transfer procedures may complicate BMI measurements and should be further studied.

26 27 RECOMMENDATIONS

28
29 The Council on Science and Public Health recommends that the following be adopted, and the
30 remainder of the report be filed.

31 32 1. Our AMA recognizes:

- 33 1. the issues with using body mass index (BMI) as a measurement because: (a) of the
34 eugenics behind the history of BMI, (b) of the use of BMI for racist exclusion, and
35 (c) BMI cutoffs are based on the imagined ideal Caucasian and does not consider a
36 person's gender or ethnicity.
- 37 2. the significant limitations associated with the widespread use of BMI in clinical
38 settings and suggests its use be in a conjunction with other valid measures of risk
39 such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity
40 index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f)
41 genetic/metabolic factors.
- 42 3. that BMI is significantly correlated with the amount of fat mass in the general
43 population but loses predictability when applied on the individual level.
- 44 4. that relative body shape and composition heterogeneity across race/ethnic groups,
45 sexes, and age-span is essential to consider when applying BMI as a measure of
46 adiposity.
- 47 5. that in some diagnostic circumstances, the use of BMI should not be used as a sole
48 criterion for appropriate insurance reimbursement. (New HOD Policy)

- 1 2. Our AMA supports further research on the application of the extended BMI percentiles and
2 z-scores and its association with other anthropometric measurements, risk factors, and
3 health outcomes. (New HOD Policy)
4
- 5 3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative
6 measures for diagnosing obesity. (New HOD Policy)
7
- 8 4. That our AMA amend policy H-440.866, “The Clinical Utility of Measuring Body Mass
9 Index and Waist Circumference in the Diagnosis and Management of Adult Overweight
10 and Obesity,” to read as follows:
11 The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and
12 Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity,
13 H-440.866
14 Our AMA supports:(1) greater emphasis in physician educational programs on the risk
15 differences ~~among ethnic and age~~ within and between demographic groups at varying
16 levels of adiposity, BMI, body composition, and waist circumference and the importance
17 of monitoring ~~these waist circumference~~ in all individuals with BMIs below 35 kg/m²; (2)
18 additional research on the efficacy of screening for overweight and obesity, using different
19 indicators, in improving various clinical outcomes across populations, including morbidity,
20 mortality, mental health, and prevention of further weight gain; and (3) more research on
21 the efficacy of screening and interventions by physicians to promote healthy lifestyle
22 behaviors, including healthy diets and regular physical activity, in all of their patients to
23 improve health and minimize disease risks. (Modify Current HOD Policy).
24
- 25 5. That our AMA amend policy H-150.965, “Eating Disorders” to read as follows: The AMA
26 (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s
27 physical and mental health as obesity; (2) asks its members to help their patients avoid
28 obsessions with dieting and to develop balanced, individualized approaches to finding the
29 body weight that is best for each of them; (3) encourages training of all school-based
30 physicians, counselors, coaches, trainers, teachers and nurses to recognize ~~unhealthy~~
31 abnormal eating behaviors, dieting, and weight restrictive behaviors in adolescents and to
32 offer education and appropriate referral of adolescents and their families for evidence-
33 based and culturally-informed interventional counseling; and (4) participates in this effort
34 by consulting with appropriate, culturally-informed educational and counseling materials
35 pertaining to ~~unhealthy abnormal~~ abnormal eating behaviors, dieting, and weight restrictive
36 behaviors. (Modify Current HOD Policy)
37
- 38 6. That our AMA not adopt Resolution 937-I-22, “Indications for Metabolic and Bariatric
39 Surgery.”

Fiscal Note: less than \$1,000

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 08-A-23

Subject: Council on Science and Public Health Sunset Review of 2013 House Policies

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

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

1 RECOMMENDATION

2

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

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-135.974	Support Stricter OSHA Silica Permissible Exposure Limit Standard	Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL. (Res. 916, I-13)	Rescind; completed. OSHA updated silica standards for industry, maritime, and construction settings in 2016.
D-135.975	Monitoring for Radiation in Seafood	Our AMA calls for the United States government to continue to monitor and fully report the radioactivity levels of edible ocean species sold in the United States. (Res. 414, A-13)	Retain; change to H-policy
D-135.980	Gulf Oil Spill Health Risks and Effects	Our AMA supports efforts by will encourage the National Institute of Environmental Health Sciences and the Natural Resource Damage Assessment program to: (1) continue to monitor health effects (including mental health effects) and public health surveillance activities related to the Gulf oil spill, and provide relevant information and resources as they become available; and (2) monitor the results of studies examining the health effects of the Gulf oil spill and report back as appropriate. (CSAPH Rep. 3, I-10; Modified: CSAPH Rep. 5, A-13)	Retain as amended; change to H-policy.
D-150.981	The Health Effects of High Fructose Syrup	Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars sweeteners , and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars caloric sweeteners in their diet. (CSAPH Rep. 3, A-08; Reaffirmation A-13)	Retain as amended and change to H policy. "Added sugars" is a more encompassing term for caloric sweeteners/sweeteners. The current Dietary Guidelines for American also references added sugars and not caloric sweeteners.
D-150.985	Folic Acid Fortification of Grain Products	Our AMA will : (1) urges the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to supports domestic and international producers of corn grain products, including masa, nixtamal,	Retain as amended; change to H-policy.

		maize, and pozole, to advocate <u>advocating</u> for folic acid fortification of such products. (CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)	
D-150.987	Addition of Alternatives to Soft Drinks in Schools	Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools. (Res. 413, A-05; Reaffirmation A-07; Reaffirmation A-12; Reaffirmation A-13)	Retain; still relevant.
D-20.992	Routine HIV Screening	Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 <u>15-65</u> , and sexually active adolescents under age 15 and adults over 65 at increased risk of infection should also be screened; (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continues to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant people women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (5) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers; (6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations. (CSAPH Rep. 2, I-06; Modified: Res. 927, I-10; Reaffirmation I-13)	Retain as amended to align with updated evidence-based guidelines.
D-220.970	Joint Commission Accreditation Standard for Pain Assessment	Our AMA urges <u>supports efforts</u> by The Joint Commission to <u>continuously</u> reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician's abilities to select the most appropriate treatment options for their patients. (Sub. Res. 915, I-13)	Retain as amended; change to H-policy.

<p>D-35.981</p>	<p>AMA Response to Pharmacy Intrusion Into Medical Practice</p>	<p>1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and unwarranted.</p> <p>2. Our AMA will work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing.</p> <p>3. If the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.</p> <p>(Res. 218, A-13)</p>	<p>Retain as amended; change to H-policy.</p>
<p>D-440.935</p>	<p>Strategies to Increase Diabetes Awareness</p>	<p>Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence.</p> <p>(Res. 412, A-13)</p>	<p>Rescind; completed. Launched programs with the YMCA to provide screenings and awareness around diabetes prevention and supported referral of patients to Diabetes Prevention Programs, a lifestyle modification program designed to reduce the risk of developing type 2 diabetes.</p>
<p>D-455.998</p>	<p>Ionizing Radiation Exposure in the Medical Setting</p>	<p>Our AMA will:</p> <p>(1) collaborate with <u>Support</u> appropriate specialty medical societies and other interested stakeholders to convene a meeting <u>collaborate</u> (a) to examine the for feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings; and (b) to discuss methods to <u>continue</u> <u>to</u> educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting;</p> <p>(2) continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health;</p> <p>(3) support education and standards for all providers and medical personnel using ionizing and non-ionizing radiation that includes awareness of, and methods to avoid, patient over-radiation;</p> <p>(4) support policies that promote the safe use of medical imaging devices, informed clinical decision-</p>	<p>Retain as amended; change to H-policy.</p>

		<p>making regarding the use of procedures that use radiation, and patient awareness of medical radiation exposure; and</p> <p>(5) encourage the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving, in both the in-patient and out-patient settings, which will help physicians discuss the potential dangers of high level of radiation exposure with patients.</p> <p>CSAPH Rep. 2, A-06; Appended: Res. 921, I-11; Reaffirmation A-13</p>	
D-455.999	Monitoring Patient Exposure to Ionizing Radiation	<p>1. Our American Medical Association will work with the support public health, radiology and radiation oncology specialty societies and all other interested parties to study <u>monitor</u> the issue of radiation exposure by <u>to</u> the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings.</p> <p>2. Our AMA: (a) will work with the American College of Radiology, the Radiological Society of North America, and other appropriate specialty medical societies and stakeholders to develop recommendations for a common format for monitoring, quantifying, documenting, and communicating the cumulative radiation exposure sustained by individual patients in medical settings that could be incorporated into a patient's personal health record and present their findings to industry; (b) recommends dissemination and use of the Physician Consortium for Performance Improvement (PCPI) 2007 Radiology Performance Improvement Measures that pertain to radiation exposure monitoring for CT scanning and fluoroscopy, and that the PCPI continue to incorporate radiation exposure issues in future performance measurement sets; and (c) supports physician and patient education on the appropriate use and risks of radiation in the medical setting.</p> <p>Res. 521, A-05; Appended: BOT Rep. 12, I-09; Reaffirmation A-13</p>	<p>Retain as amended; change to H-policy.</p> <p>Part two of the resolution is complete.</p>
D-460.983	Translating Biomedical Research to the Bedside	<p>Our AMA will: (1) give high priority to bringing promising biomedical research to the bedside; and (2) advocate for the elimination of unreasonable barriers to bedside care using new research.</p> <p>(Res. 812, I-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; change to H policy.
D-490.983	Annual Tobacco Report 2003	<p>Our AMA will continue to produce the Annual Tobacco Report.</p> <p>(BOT Rep. 7, I-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
D-515.985	Elder Mistreatment	<p>Our AMA:</p> <p>1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams</p>	Retain; change to H policy.

		<p>and assume greater roles as medical advisors to APS services.</p> <p>2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.</p> <p>3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.</p> <p>4. Encourages substantially more research in the area of elder mistreatment.</p> <p>5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.</p> <p>6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated.</p> <p>7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation.</p> <p>(CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13)</p>	
D-55.998	Encourage Appropriate Colorectal Cancer Screening	Our AMA, in conjunction with interested organizations and societies, will supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups. (Res. 510, A-03; Modified: CSAPH Rep. 1, A-13)	Retain as amended; change to H policy.
H-10.966	Prevention of Fires Related to Cigarette Smoking	The AMA (1) supports studies to determine the feasibility and practicality of establishing a standard for self-extinguishing cigarettes and requiring cigarette manufacturers to meet that standard; (2) supports the concept of self-extinguishing cigarettes for the purpose	Retain; still relevant.

		of reducing fire related deaths, injuries and loss of property; and (3) reiterates its opposition to all smoking. (Sub. Res. 6, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-10.981	Prohibition on the Public Sale of Fireworks	Our AMA (1) encourages accurate reporting of fireworks related injuries, deaths, and fires; (2) supports all efforts designed to prohibit the public sale, including those by mail order, of all fireworks; (3) supports existing efforts to educate physicians, parents, children, and community leaders about the dangers of fireworks; and (4) encourages the adoption of federal legislation prohibiting the sale of fireworks and their use, with the exception of those used for professional displays. (Res. 419, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-10.995	Use of Technology to Prevent Explosions	The AMA encourages manufacturers of automobiles, boats, and other vehicles, as well as makers of containers of volatile liquids and gases, to incorporate appropriate safety technology into the development of their products. (Res. 59, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-100.976	Benzodiazepine Education	Our AMA encourages physicians interested in the addictive nature of benzodiazepines and their rational use to seek information from appropriate sources. (CSA Rep. E, A-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-130.992	Proposed Crisis Relocation and Shelter Plans	Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude. (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; duplicative of more comprehensive policy (H-130.942 , D-130.972 , and D-130.974).
H-130.993	Use of Emergency Medical Information Aids	The AMA (1) endorses and encourages the use of effective medical information aids by which appropriate individual medical information can be brought to the attention of emergency personnel; and (2) supports continued review of existing medical information aids to determine appropriate steps to encourage greater use of those information aids which are considered effective. (Res. 57, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended.
H-135.948	Toxicity of Computers and Electronics Waste	Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous	Retain; still relevant.

		<p>electronic waste to developing countries and safely dispose of the waste that <u>cannot</u> be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials. (Res. 423, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
H-135.961	Risks of a High-Level Radioactive Waste Repository	<p>The AMA (1) strongly encourages the U.S. Nuclear Regulatory Commission and the Nuclear Waste Technical Review Board of the National Research Council to include representatives of the appropriate state medical societies/associations, the AMA, and appropriate medical specialty groups with expertise in the field to advise and/or act as consultants to those entities; and (2) urges the U.S. Congress to establish a site for a high-level radioactive waste repository. (BOT Rep. A, I-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-145.978	Gun Firearm Safety	<p>Our AMA: (1) recommends and promotes the use of trigger locks and locked gun <u>firearm</u> cabinets as safety precautions; and (2) endorses <u>supports</u> standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)</p>	Retain as amended; still relevant. Terminology updated for consistency.
H-145.988	AMA Campaign to Reduce Firearm Deaths	<p>The AMA supports educating the public regarding methods to reduce death and injury due to keeping <u>firearms</u> guns, ammunition and other explosives in the home. (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)</p>	Retain as amended; still relevant. Terminology updated for consistency.
H-15.954	Older Driver Safety	<p>(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and: (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly; (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving</p>	Retain; still relevant.

		<p>safety cannot be maintained through medical interventions or driver rehabilitation;</p> <p>© urges physicians to know and adhere to their state’s reporting statutes for medically at-risk drivers; and</p> <p>(d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.</p> <p>(2) Our AMA encourages physicians to use the Physician’s Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients. (CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
H-15.964	Police Chases and Chase-Related Injuries	<p>The AMA encourages (1) communities, aided by government officials and medical scientists, to develop <u>and implement</u> guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.</p> <p>(CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	<p>Retain as amended. In 2015, a model policy was created by the International Association of Chiefs of Police. In it, the policy states, “Pursuit is authorized only if the officer has a reasonable belief that the suspect, if allowed to flee, would present a danger to human life or cause serious injury. In general, pursuits for minor violations are discouraged”</p>
H-150.966	FDA Regulations Regarding the Inclusion of Added L-Glutamic Acid Content on Food Labels	<p>Until such time as L-glutamic acid in any form has been shown to pose a significant public health hazard or until biological non-equivalence of monosodium glutamate and L-glutamate has been demonstrated, the AMA supports the exclusion of L-glutamic acid released from hydrolyzed protein from food product labeling requirements.</p> <p>(CSA Rep. D, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	<p>Retain; still relevant.</p>
H-170.965	Education on Condom Use	<p>Our AMA: (1) Supports joining with appropriate medical and public health organizations and federal agencies in endorsing the use of condoms in reducing the risk of HIV/AIDS and other sexually transmissible diseases among the population; (2) Encourages the production of condom education materials that meet standards of accuracy, completeness, social appropriateness, clarity, and simplicity; (3) Supports cooperating with other medical societies, the public health community, government agencies, and the media to develop standards for public service announcements regarding condom use in prevention of HIV/AIDS and other sexually transmissible diseases; and (4) In cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about the role of condom use in reducing the risk of sexually transmissible diseases, including HIV</p>	<p>Retain; still relevant.</p>

		disease. While such counseling may not be appropriate for all patients, physicians should be encouraged to provide this information to any patient who may benefit from being more aware of the risks of sexually transmissible diseases. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-170.966	Human Sexuality Education	Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; Duplicative of policy H-170.968
H-170.967	Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System	Our AMA supports comprehensive health education for female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for girls who have been victimized. (Res. 411, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; more recent policy exists including D-60.994 , D-430.997 , and H-515.981 .
H-175.992	Deceptive Health Care Advertising	Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising. (Sub. Res. 102, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 13, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 6, A-13)	Retain; still relevant.
H-20.899	HIV Testing	Our AMA endorses routine HIV screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician. It is AMA policy that: (1) this testing should be a voluntary program in which patients may opt out if they desire not to be tested; (2) HIV screening permission be incorporated into general health care consent forms and that separate written consent is not recommended; (3) prevention counseling should not be a requirement for this testing program; (4) when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission and dissemination of the virus; and (5) when positive HIV patients are identified, appropriate linkage to HIV care be established. (Res. 2, A-07; Reaffirmation I-13)	Rescind; Duplicative of H-20.920
H-20.903	HIV/AIDS and Substance Abuse	Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that <u>people who use drugs</u> abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among <u>persons who inject drugs</u> intravenous drug abusers ; (2) advocates development of regulations and incentives to encourage retention of HIV-positive	Retain as amended; updating language.

		<p>and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of <u>persons who inject drugs intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic</u>. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for <u>persons who inject drugs intravenous drug abusers</u> and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant <u>people who inject drugs intravenous drug abusers</u> and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers <u>users</u>, especially homeless, runaway, and detained adolescents who are <u>living with HIV seropositive or AIDS symptomatic</u> and those whose lifestyles with risk factors place them at risk for contracting <u>living with HIV seropositive or AIDS symptomatic</u> and those whose lifestyles with risk factors place them at risk for contracting HIV infection. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
<p>H-20.907</p>	<p>Financing Care for HIV/AIDS Patients</p>	<p>Our AMA: (1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative; (2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits; (3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems; (4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;</p>	<p>Retain as amended; still relevant.</p>

		<p>(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;</p> <p>(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;</p> <p>(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;</p> <p>(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.</p> <p>(CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)</p>	
H-20.910	HIV-Infected Children	<p>Our AMA:</p> <p>(1) Supports day-care, preschool, and school attendance of HIV-infected children;</p> <p>(2) Encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to his/her health;</p> <p>(3) Encourages that HIV-infected children who are adopted or placed in a foster-care setting have access to special health care benefits to encourage adoption or foster-care.</p> <p>(CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-20.916	Breastfeeding and HIV Seropositive Women <u>People</u>	<p>Our AMA believes that, where safe and alternative nutrition is widely available, HIV seropositive women <u>people</u> should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption.</p> <p>(CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain as amended to include gender-neutral language.
H-20.917	Neonatal Screening for HIV Infection	<p>Our AMA: (1) urges the U.S. Public Health Service, other appropriate federal agencies, private researchers, and health care industries to continue to pursue research, development, and implementation of diagnostic tests and procedures for more accurate demonstration of HIV infection in the newborn; and supports the widespread use of such tests in early diagnosis; (2) favors giving consideration to rapid HIV testing of newborns, with <u>maternal consent of the</u></p>	Retain as amended.

		<p>gestational parent, when the maternal individual's HIV status has not been determined during pregnancy or labor; and (3) supports mandatory HIV testing of all newborns in high prevalence areas. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-20.919	Patient Disclosure of HIV Seropositivity	<p>Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-245.983	Baby Walkers	<p>The AMA strengthens its policy on baby walkers by urging <u>urges</u> the Consumer Product Safety Commission to ban infant walkers as a mechanical hazard. (Res. 403, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain as amended; still relevant.
H-245.985	Mandatory Labeling for Waterbeds and Beanbag Furniture	<p>The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. (Res. 414, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-280.958	Pain Control in Long-Term Care	<p>Our AMA will work: (1) to promote promulgate clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients. (Res. 715, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 518, A-12; Reaffirmation A-13)</p>	Retain as amended to clarify the AMA's role in clinical practice guidelines.
H-365.996	Regulation of Occupational Carcinogens	<p>The AMA endorses the principle of supports using the best available scientific data, including data derived from animal models, as a basis for regulation of occupational carcinogens. (Sub. Res. 81, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain as amended; still relevant.
H-370.984	Organ Donation Education	<p>Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes. (Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Modified: Res. 3, A-13)</p>	Retain; still relevant.
H-420.991	Fetal Effects of Maternal Alcohol Use	<p>The AMA believes that (1) The evidence is clear that a woman <u>person</u> who drinks heavily during pregnancy places her <u>their</u> unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse <u>use</u> and alcoholism <u>alcohol use disorder</u> in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as</p>	Retain as amended; still relevant.

		<p>possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group.</p> <p>(2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal <u>gestational</u> alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal <u>gestational</u> alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent.</p> <p>(3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence.</p> <p>(4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake.</p> <p>(5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations.</p> <p>(6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal <u>gestational</u> drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations. (CSA Rep. E, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
<p>H-425.971</p>	<p>Celiac Disease Screening</p>	<p>Our AMA: (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (Res. 419, A-13)</p>	<p>Retain; still relevant.</p>
<p>H-430.988</p>	<p>Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities</p>	<p>(1) Medical Testing and Care of Inmates Prisoners <u>Inmates</u> a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners inmates <u>inmates</u> should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d)</p>	<p>Retain as amended; updating language to be consistent with current policy.</p>

		<p>Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners <u>Inmates</u> should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-440.842	Recognition of Obesity as a Disease	Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. (Res. 420, A-13)	Retain; still relevant.
H-440.843	Health Risks of Sitting	Our AMA recognizes that there are potential risks of prolonged sitting, encourages efforts by employers, employees, and others to make available alternatives such as standing work stations and isometric balls, and encourages educational efforts regarding ways to minimize this risk. (Res. 413, A-13)	Retain; still relevant
H-440.866	The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity	Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m ² ; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in	Retain; still relevant.

		<p>improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.</p> <p>(CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13)</p>	
H-440.898	<p>Recommendations on Folic Acid Supplementation</p>	<p>Our AMA will:</p> <p>(1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD);</p> <p>(2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD;</p> <p>(3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states;</p> <p>(4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products;</p> <p>(5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and</p> <p>(6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and</p> <p>(7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)</p>	<p>Retain; still relevant.</p>
H-440.931	<p>Update on Tuberculosis</p>	<p>It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its</p>	<p>Retain as amended; updating language.</p>

		<p>transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added. (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-440.934	Adequacy of Sterilization in Commercial Enterprises	<p>The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-440.966	Elimination of Tuberculosis as a Public Health Problem	<p>The AMA (1) endorses the Strategic Plan for the Elimination of Tuberculosis, as developed by the CDC Division of Tuberculosis Elimination Advisory Committee for the Elimination of Tuberculosis; (2) supports cooperative efforts with other national medical and public health organizations to help implement the policies of the Strategic Plan for the Elimination of Tuberculosis; (3) supports the promulgation of information on the appropriate methods for evaluating, diagnosing, treating, and preventing tuberculosis; (4) encourages and assists state and county medical associations to work with state, county and city health officials to achieve the long-range objective of reducing the incidence of active tuberculosis in the United States to one case per million before the year 2010; and (5) supports use of a tuberculosis risk assessment questionnaire in US school aged children when appropriate, with follow-up TB testing based on the results of that TB risk assessment. (Res. 75, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Appended: Res. 515, A-13)</p>	Retain as amended; updated language to be consistent with the current goals.
H-455.980	National Biomedical Tracer Facility	<p>The AMA supports the establishment of a National Biomedical Tracer Facility with federal funding to serve as a national resource for clinical medicine, research and education. (Res. 513, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.

<p>H-455.994</p>	<p>Risks of Nuclear Energy and Low-Level Ionizing Radiation</p>	<p>Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.</p> <p>(2) Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.</p> <p>(3) Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.</p> <p>(4) Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning. Local laws should be modified to allow the disposal of low level radioactive waste materials in accordance with AMA model state legislation.</p> <p>(5) Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.</p> <p>(6) Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.</p> <p>(7) Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.</p> <p>(8) Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local</p>	<p>Retain as amended; still relevant.</p>
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<p>H-460.903</p>	<p>Commercialized Medical Screening</p>	<p>Our AMA supports the funding of well-designed, large-scale clinical trials aimed at determining the safety, value, and cost-effectiveness of screening imaging procedures.</p> <p>(CSA Rep. 10, A-03; Modified: CSAPH Rep. 1, A-13)</p>	<p>Retain; still relevant.</p>
<p>H-460.915</p>	<p>Cloning and Stem Cell Research</p>	<p>Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood</p>	<p>Retain; still relevant.</p>

		stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology. (CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-470.972	Medical and Nonmedical Uses of Anabolic-Androgenic Steroids	Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs; (2) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and (3) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis. (CSA Rep. A, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-01; Modified: CSA Rep. 9, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.956	Commercialized Medical Screening	AMA policy is that relevant specialty societies continue to evaluate the validity and clinical use of screening imaging procedures that are advertised directly to the public and make available to the broader physician community unbiased evaluations to help primary care physicians advise their patients of the risks and benefits of these procedures. (CSA Rep. 10, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.966	Multiplex DNA Testing for Genetic Conditions	Policy of the AMA is that: (1) tests for more than one genetic condition should be ordered only when clinically relevant and after the patient or parent/guardian has had full counseling and has given informed consent; (2) efforts should be made to educate clinicians and society about genetic testing; and (3) before genetic testing, patients should be counseled on the familial implications of genetic test results, including the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. (CEJA Rep. 1, I-96; Appended: BOT Rep. 16, I-99; Modified: CSA Rep. 3, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.978	Medical Innovations	It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers.	Retain; still relevant.

		(Sub. Res. 508, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-485.995	TV Violence	The AMA reaffirms its vigorous opposition to television violence and its support for efforts designed to increase the awareness of physicians and patients that television violence is a risk factor threatening the health of young people. (Res. 19, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)	Retain, still relevant.
H-490.906	Enhanced Education for Abrupt Cessation of Smoking	Our AMA encourages research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals. (Res. 408, A-13)	Retain; still relevant.
H-490.914	Tobacco Prevention and Youth	(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material; (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or <u>childcare</u> purposes; (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities; (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign. (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;	Retain as amended; still relevant.

		<p>(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;</p> <p>(7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;</p> <p>(8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and</p> <p>(9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).</p> <p>(CSA Rep. 3, A-04; Modified: Res. 402, A-13)</p>	
<p>H-495.985</p>	<p>Smokeless Tobacco</p>	<p>Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA:</p> <p>(1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs;</p> <p>(2) objects strongly to the introduction of "smokeless" cigarettes;</p> <p>(3) opposes the use of smokeless tobacco products by persons of all ages;</p> <p>(4) urges that the same requirements and taxes placed on cigarette sales and advertising be applied to smokeless tobacco products;</p> <p>(5) supports legislation to prohibit the sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on purchasing and distributing all tobacco products to individuals under the age of 21 years;</p> <p>(6) supports public and school educational programs on the health effects of smokeless tobacco products;</p> <p>(7) urges the commissioners of professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and recommends that</p>	<p>Retain; still relevant.</p>

		<p>professional athletes participate in media programs that would discourage the youth of America from engaging in this harmful habit; and</p> <p>(8) is committed to exerting its influence to limit exposure of young children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers take steps to diminish the appeal of snuff and chewing tobacco to young persons. (CSA Rep. 3, A-04; Reaffirmation A-13)</p>	
H-5.985	Fetal Tissue Research	<p>The AMA supports the use of fetal tissue obtained from induced abortion for scientific research. (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-50.975	Safety of Blood Donations and Transfusions	<p>Our AMA:</p> <p>(1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion;</p> <p>(2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS;</p> <p>(3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and</p> <p>(4) Supports providing educational information to physicians on alternatives to transfusion. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-50.976	Blood Bank Look-Back Programs	<p>Our AMA supports the concept of blood bank look-back recipient notification programs as a means of protecting patients and reducing the possible spread of infections. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-50.977	Blood Donor Recruitment	<p>Our AMA: (1) supports the establishment of a national volunteer blood donor education and recruitment campaign to assure an adequate and readily available blood supply; and (2) supports scientifically-based policies that ensure the safety of the nation's blood supply. (Sub. Res. 401, A-02; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-50.982	Autologous Blood Transfusions	<p>The AMA (1) supports the collection of autologous blood from candidates for elective surgery who are without contraindications to phlebotomy and when such donations are medically indicated because transfusion is likely to be needed; and (2) supports efforts to remove economic barriers to the collection and use of autologous blood for transfusion, in order to promote its wider use. (CSA Rep. A, I-92; Modified: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-515.981	Family Violence-Adolescents as Victims and Perpetrators	<p>The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider</p>	Retain; still relevant.

		<p>issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.</p> <p>(CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-515.982	Violent Acts Against Physicians	<p>Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity; (3) will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers; and (4) will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise.</p> <p>(Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13)</p>	Retain; still relevant.
H-60.925	Effects of Alcohol on the Brains of Underage Drinkers	<p>Our AMA supports creating a higher level of awareness about the harmful consequences of underage drinking.</p> <p>(CSA Rep. 11, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-60.926	Prevention of Falls Through Windows	<p>Our AMA: (1) supports the use of window guards and devices that prevent children from falling through windows; and (2) supports public education regarding the risks of children falling through windows.</p> <p>(Res. 415, A-13)</p>	Retain; still relevant.
H-60.941	Effects of Alcohol on the Brains of Underage Drinkers	<p>Our AMA encourages increased medical and policy research on the harmful effects of alcohol on adolescents and young adults and on the design and implementation of environmental strategies to reduce youth access to, and high consumption of, alcohol.</p>	Retain as amended; still relevant.

		(CSA Rep. 11, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-60.945	Neonatal Male Circumcision	<p>1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV."—and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.</p> <p>2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision. (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)</p>	Retain as amended; still relevant.
H-60.963	Preventable Airway Obstructions in Children	<p>The AMA supports educational programs to apprise the public of the dangers of airway obstruction hazards in children and on methods to prevent these hazards. (Res. 412, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	<p>1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.</p> <p>2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. (Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13)</p>	Retain; still relevant.
H-60.975	Political Influence and the NIH	<p>Our AMA (1) reaffirms its support for the long standing, uniformly accepted and merit-based scientific peer review system utilized by federal research agencies, including the National Institutes of Health; and (2) deplors the use of political influence to override decisions to support research proposals when those decisions were derived from scientific peer review. (Res. 526, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 725, I-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.

<p>H-75.994</p>	<p>Contraception and Sexually Transmitted Diseases Infections</p>	<p>Our AMA, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted diseases infections, including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexually transmitted diseases infections.</p> <p>(BOT Rep. E, A-89; Reaffirmation A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	<p>Retain as amended; still relevant.</p>
<p>H-90.977</p>	<p>Impairment and Disability Evaluations</p>	<p>It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations.</p> <p>(CSA Rep. 8, I-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	<p>Retain; still relevant.</p>
<p>H-95.954</p>	<p>The Reduction of Medical and Public Health Consequences of Drug Use Abuse</p>	<p>Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse <u>misuse</u> aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5)</p>	<p>Retain as amended; still relevant.</p>

		<p>encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients <u>who inject drugs with injection drug addiction</u> in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)</p>	
H-95.956	Harm Reduction Through Addiction Treatment	<p>The AMA endorses <u>supports</u> the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of <u>alcohol use disorders alcoholism</u> and other drug dependencies <u>substance use disorders</u> and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy. (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain as amended; still relevant.
H-95.961	Policy on Illegal <u>Illicit</u> Drug Use	<p>The AMA discourages and condemns illegal <u>illicit</u> drug use, and encourages physicians to do all in their power to discourage the use of illegal <u>illicit</u> drugs in their communities and to refuse to assist anyone in obtaining drugs for non-medical use. (Res. 523, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Rescind based on stigmatizing language and discordance with more recent policy.
H-95.984	Issues in Employee Drug Testing	<p>The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders, and (d) urine, alcohol and other drug testing of all physicians and appropriate employees of health</p>	Retain; still relevant.

		<p>care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13)</p>	
H-95.997	Cannabis Intoxication as a Criminal Defense	<p>Our AMA believes a plea of cannabis intoxication not be a defense in any criminal proceedings. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)</p>	Retain; still relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-23)

Introduced by: Washington

Subject: Metered Dose Inhalers and Greenhouse Gas Emissions

Referred to: Reference Committee D

1 Whereas, Climate change is a risk multiplier that threatens to unravel decades of development
2 gains; and
3
4 Whereas, Nearly 10% of all US greenhouse gas emissions are from health care; and
5
6 Whereas, The house of medicine has a responsibility to limit its contribution to climate change
7 because of its impact on human health; and
8
9 Whereas, The use of hydrofluorocarbons is a known contributor to climate change; and
10
11 Whereas, Metered-dose inhalers (MDIs) use hydrofluorocarbons as a propellant, making a
12 significant contribution to the health care sector's greenhouse gas emissions; and
13
14 Whereas, MDIs remain an important part of asthma and COPD care and need to still be
15 available, as dry-powdered inhalers are not the best option for everyone, dry-powdered inhalers
16 nonetheless have been shown to have equal or superior efficacy and tolerability to MDIs, and
17 thus should be developed and made available; therefore be it
18
19 RESOLVED, That our American Medical Association study the climate effects of metered-dose
20 inhalers, options for reducing hydrofluorocarbon use in the medical sector, and strategies for
21 encouraging the development of alternative inhalers with equal efficacy and less adverse effect
22 on our climate. (Directive to Take Action)

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

Received: 2/14/23

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.

2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-23)

Introduced by: Young Physicians Section

Subject: Encouraging Discussion of Family Planning Counseling as Part of
Recommended Routine Health Maintenance

Referred to: Reference Committee D

1 Whereas, According to several organizations, for couples in which the female partner is under
2 35 years of age, “infertility is a disease historically defined by the failure to achieve a successful
3 pregnancy after 12 months or more of regular, unprotected sexual intercourse”¹; and
4

5 Whereas, Infertility affects 10-15% of couples,² but affects approximately 25% of female
6 physicians, with the rate of female physicians seeking fertility evaluation and treatment at six
7 times higher than that of the general population^{3,4,5}; and
8

9 Whereas, Women of advanced maternal age have increased risks of adverse pregnancy
10 outcomes, including lower chances of live birth and increased risks of miscarriage and birth
11 defects⁶; and
12

13 Whereas, The peak child-bearing years unfortunately correspond to the peak career-building
14 years for many; and
15

16 Whereas, According to the American College of Obstetricians and Gynecologists and the
17 American Society for Reproductive Medicine, “the goal of pre-pregnancy care is to reduce the
18 risk of adverse health effects for the woman, fetus, and neonate by working with the woman to
19 optimize health, address modifiable risk factors, and provide education about healthy
20 pregnancy”⁷; and
21

22 Whereas, “Pre-pregnancy counseling is appropriate whether the reproductive-aged patient is
23 currently using contraception or planning pregnancy. Because health status and risk factors
24 can change over time, pre-pregnancy counseling should occur several times during a woman’s
25 reproductive lifespan, increasing her opportunity for education and potentially maximizing her
26 reproductive and pregnancy outcomes”⁷; and
27

28 Whereas, “Many chronic medical conditions such as diabetes, hypertension, psychiatric illness,
29 and thyroid disease have implications for pregnancy outcomes, and should be optimally
30 managed before pregnancy”⁷; and
31

32 Whereas, “Male infertility may occasionally be the presenting manifestation of an underlying life-
33 threatening condition,” and so the evaluation of the infertile male includes identification of “life-
34 or health-threatening conditions that may underlie... fertility or associated medical comorbidities
35 that require medical attention”⁸; and
36

37 Whereas, “The burden of infertility includes psychological, social and physical suffering.
38 Documented consequences include: anxiety, depression, lowered life satisfaction, grief, fear,
39 guilt, helplessness, reduced job performance, marital duress, dissolution and abandonment;

1 economic hardship, loss of social status, social stigma, social isolation and alienation,
2 community ostracism, and physical violence”^{9, 10, 11, 12}; and
3

4 Whereas, The consequences of unwanted childlessness can “vary considerably, from an almost
5 universal decrease in well-being in infertile individuals, to significant emotional and
6 psychological effects, disruption in social relationships and, at the severe end of the spectrum,
7 death due to domestic violence, suicide or starvation and disease exacerbated by neglect”^{9, 10}. ;
8 and
9

10 Whereas, “It is often argued that public resources should not be used to help infertile couples
11 reproduce when the planet is already home to a huge (and growing) population which may not
12 be able to be sustainably supported,” but this overpopulation argument “denies the importance
13 of reproductive autonomy and distributes social responsibility for population pressures unfairly
14 on the infertile”^{9,10}; and
15

16 Whereas, “Infertility is often denied classification as a public health issue because of concerns
17 over the cost of treatment,” but cost-effective and creative solutions to infertility (such as
18 preventing STIs) are potentially available, and infertility treatment should be considered part of
19 international efforts to promote women’s reproductive health¹⁰; and
20

21 Whereas, The discipline of public health can should be used to address infertility, by raising
22 awareness of the scope and significance of unwanted childlessness, improving collection and
23 surveillance of health data, generating informed public debate, and developing public policies on
24 infertility and its treatment; and
25

26 Whereas, The U.S. Preventive Services Task Force¹³ works to improve the health of people
27 nationwide by making evidence-based recommendations about clinical preventive services;
28 therefore be it
29

30 RESOLVED, That our American Medical Association work with other stakeholders to encourage
31 discussion of family planning counseling with all individuals with reproductive potential as part of
32 routine health maintenance. (Directive to Take Action)

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

Received: 3/17/23

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RELEVANT AMA POLICY

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving **preconception** health **care** that state:

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of **preconception** health behaviors and **preconception care** services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary **care** visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to **preconception** risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
- (5) Inter-conception **care**--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
- (6) Pre-pregnancy checkup--offer, as a component of maternity **care**, one pre-pregnancy visit for couples and persons planning pregnancy;
- (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception **care**;
- (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
- (9) Research--increase the evidence base and promote the use of the evidence to

improve **preconception** health; and

(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor **preconception** health.

2. Our AMA supports the education of physicians and the public about the importance of **preconception care** as a vital component of a woman's reproductive health.

3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-**care** and recommend it be appropriately documented in the medical record.

Citation: Res. 414, A-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17Appended: Res. 401, A-19

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

Resident and Fellow Access to Fertility Preservation H-310.902

Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

Citation: Res. 302, A-22;

E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover **assisted reproductive** services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients.

Physicians who offer **assisted reproductive** services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-23)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and
Detention Centers

Referred to: Reference Committee D

- 1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people
2 who have been accused and/or convicted of a crime¹; and
3
- 4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,
5 people awaiting trial or sentence, or young offenders for short periods of time²; and
6
- 7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual
8 confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary
9 violations in correctional facilities and detention centers³; and
10
- 11 Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as
12 not standing up for headcount or not returning a food tray^{3,4}; and
13
- 14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means
15 of reprisal for reporting unsafe and unsanitary conditions^{5,6}; and
16
- 17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of
19 infectious disease⁷; and
20
- 21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary
23 measure overseen by medical professionals who treat prisoners with compassion and provide
24 prisoners resources to aid their recovery⁷; and
25
- 26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around
27 60,000 people, currently reside in some form of solitary confinement⁸; and
28
- 29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average
30 of \$75,000 per prisoner per year⁹; and
31
- 32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are
33 offered few or no educational, vocational, or rehabilitative programs¹⁰; and
34
- 35 Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated
36 with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic
37 stress disorder, and psychosomatic behavior changes¹¹⁻¹³; and

1 Whereas, There is a strong association between solitary confinement and self-harm, for
2 instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher
3 suicide rate within the first year after release and another study analyzing over 240,000
4 incarcerations found that prisoners who experienced solitary confinement accounted for over
5 50% of self-harm incidents despite accounting for only 7.3% of prison admissions^{4,13,14}; and
6

7 Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an
8 opioid overdose in the first two weeks after release and 24% more likely to die from any cause
9 in the first year after release, even after controlling for potential confounding factors, including
10 substance use and mental health disorders¹⁴; and
11

12 Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a
13 higher overall 5-year mortality than those who do not¹⁵; and
14

15 Whereas, A United States Department of Justice study indicates that inmates with mental
16 illnesses are more likely to be put in solitary confinement and that solitary confinement further
17 exacerbates their mental illnesses¹⁶; and
18

19 Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term
20 neurobiological consequences, increasing mentally ill prisoners' need for psychiatric
21 services^{12,13}; and
22

23 Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of
24 homelessness and unemployment after release, in part due to the lasting psychological stress
25 of confinement¹⁷; and
26

27 Whereas, Spending any amount of time in solitary confinement is associated with two times the
28 risk of being reincarcerated within two weeks of release and other studies found a 10-25%
29 increased overall risk of recidivism^{14,18-20}; and
30

31 Whereas, Parolees released from solitary confinement commit new crimes in their community
32 35% more than parolees released from the general prison population, threatening community
33 safety¹⁹; and
34

35 Whereas, Transitioning prisoners from solitary confinement to the general prison population
36 prior to release reduces recidivism rates²⁰; and
37

38 Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions,
39 certain racial minorities are disproportionately more likely to be placed in solitary confinement
40 while white prisoners are 14% less likely to be placed in solitary confinement⁸; and
41

42 Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will
43 be placed in solitary confinement are 80% greater than heterosexual men and the odds are
44 190% greater that lesbian and bisexual women will be placed in solitary confinement than
45 heterosexual women²¹; and
46

47 Whereas, The United Nations and The International Convention on the Rights of the Child
48 prohibit the solitary confinement of anyone under the age of 18^{22,23}; and
49

50 Whereas, In 2015 the United Nations General Assembly adopted "The Standard Minimum
51 Rules for the Treatment of Prisoners," also known as the "Mandela Rules," which condemn the

1 use of solitary confinement for prisoners with mental or physical disabilities when their
2 conditions would be exacerbated by such measures²³; and

3
4 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than
5 15 days, because it is “cruel, inhuman or degrading treatment or punishment”²³; and

6
7 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in
8 exceptional cases as a last resort, for as short a time as possible and subject to independent
9 review”²³; and

10
11 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical
12 and psychological health issues, and should be considered cruel and unusual punishment and a
13 human rights violation²⁴; and

14
15 Whereas, At least some United States correctional facilities have managed to reform and
16 reduce their use of solitary confinement in order to better respect the dignity and human rights
17 of inmates while still maintaining the safety of correctional officers and inmates in jails and
18 prisons¹⁸; and

19
20 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%
21 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff
22 violence¹⁸; and

23
24 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement
25 population, violent incidents also dropped by nearly 70%¹⁹; and

26
27 Whereas, A 2015 study found that placing male inmates who were violent in solitary
28 confinement did not effectively deter or alter the probability, timing, or development of future
29 misconduct or violence²⁵; and

30
31 Whereas, Some correctional facilities have created special units to protect vulnerable groups
32 together with similar access to privileges and programs available to the general population
33 without using solitary confinement as a means of protection¹⁸; and

34
35 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for
36 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New
37 York City²⁶; and

38
39 Whereas, American Medical Association policy H-60.922 opposes the use of solitary
40 confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

41
42 RESOLVED, That our American Medical Association policy H-430.983 be amended by addition
43 and deletion to read as follows:

44
45 **Reducing ~~Opposing~~ the Use of Restrictive Housing in for**
46 **Prisoners with Mental Illness H-430.983**

47 Our AMA will: (1) ~~support limiting~~ oppose the use of solitary
48 confinement of any length, ~~with rare exceptions~~, for incarcerated
49 persons ~~with mental illness~~, in adult correctional facilities and
50 detention centers, except for medical isolation or to protect
51 individuals who are actively being harmed or will be immediately
52 harmed by a physically violent individual, in which cases

1 confinement may be used for as short a time as possible; and (2)
2 while solitary confinement practices are still in place, support
3 efforts to ensure that the mental and physical health of all
4 individuals placed in solitary confinement are regularly monitored
5 by health professionals; and (3) encourage appropriate
6 stakeholders to develop and implement safe, humane, and ethical
7 alternatives to solitary confinement for incarcerated persons in all
8 correctional facilities.; and (3) encourage appropriate stakeholders
9 to develop and implement alternatives to solitary confinement for
10 incarcerated persons in all correctional facilities. (Modify Current
11 Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Citation: Res. 412, A-18;

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Citation: Res. 001, A-18;

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, 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 for 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; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22;

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Citation: (Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15)

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Citation: (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14)

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoners genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-23)

Introduced by: Medical Student Section

Subject: Additional Interventions to Prevent Human Papillomavirus (HPV) infection
and HPV-Associated Cancers

Referred to: Reference Committee D

1 Whereas, Human papillomavirus (HPV) is the most common sexually transmitted infection and
2 is known to cause cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancer¹; and
3

4 Whereas, Smoking, immunosuppression, a history of Chlamydia infection, long term oral
5 contraceptive use, and an increased number of sexual partners is associated with higher risk of
6 developing cervical cancer^{1,2}; and
7

8 Whereas, No current screening test exists to detect HPV infection in people who have penises⁴;
9 and
10

11 Whereas, No current screening test exists to detect HPV infection in the oropharynx⁴; and
12

13 Whereas, From 1995-2012, the proportion of oropharyngeal squamous cell carcinomas driven
14 by HPV infection increased substantially in people with penises (36% to 72%) and people with
15 cervixes (29% to 77%)⁵; and
16

17 Whereas, The nine-valent HPV vaccination is efficacious against HPV strains known to cause
18 anogenital warts, cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancers^{1,8}; and
19

20 Whereas, HPV vaccination programs in the United States have been expanded beyond female-
21 only programs to prevent HPV infection in all people⁶; and
22

23 Whereas, HPV vaccination is now FDA approved up to 46 years of age for all people, and is
24 recommended routinely for individuals aged 11-26 and may be recommended in 27-45 year-
25 olds after discussion with their clinician⁹; and
26

27 Whereas, Carceral facilities have limited history of providing HPV vaccinations, while
28 incarcerated individuals have low self-reported vaccination rates compared to the non-
29 incarcerated population^{10,11}; and
30

31 Whereas, Most incarcerated women between 18-26 years of age have not received HPV
32 immunization but would be willing to if offered¹¹; and
33

34 Whereas, People with criminal-legal histories are five times more likely to develop cervical
35 cancer in their lifetimes than the general population¹⁰; and
36

37 Whereas, The Federal Bureau of Prisons' Clinical Guidelines support routine cervical cancer
38 screening in carceral facilities as a means of cervical cancer prevention⁶; and

1 Whereas, Many carceral facilities under state and federal jurisdiction are not equipped to
2 provide basic gynecological medical care including gynecologic testing and procedures that
3 require specialized diagnostic equipment⁷; and
4

5 Whereas, Some carceral facility administrators and local health departments have
6 demonstrated an interest in providing HPV vaccination to people who are incarcerated^{12,13}; and
7

8 Whereas, Successful HPV vaccination programs have been introduced through collaborations
9 between carceral facilities and health departments^{12,13}; and
10

11 Whereas, Between 32% and 42% of formerly incarcerated individuals were medically insured
12 eight to ten months after release from their carceral facility¹⁴; and
13

14 Whereas, Uninsured and underinsured individuals are unlikely to have access to routine and
15 preventive medical care, including HPV immunization and cervical dysplasia treatment¹⁵; and
16

17 Whereas, A 2019 analysis from the US National Health Interview Survey guideline-concordant
18 cervical cancer screening showed disparities in cervical cancer screening by race, sexual
19 orientation, and rural residency¹⁶; and
20

21 Whereas, These disparities resulted in a lack of timely diagnosis and treatment for cervical pre-
22 cancers, leading to worse outcomes and disparities in mortality from cervical cancer^{17,18}; and
23

24 Whereas, Black women had a 19% increase in mortality risk compared to white women despite
25 controlling for age, stage, histology, and treatment¹⁷; and
26

27 Whereas, Barriers to screening include personal and structural barriers such as distrust in the
28 healthcare system, transportation, cost, time off work, and lack of access to facilities equipped
29 for cervical cancer screening^{17,18}; and
30

31 Whereas, Screening for HPV commonly consists of so-called “primary screening” for high risk
32 HPV (hrHPV) DNA in samples from a patient’s cervix using polymerase chain reaction (PCR),
33 and cytology wherein cervical samples are microscopically examined for presence of dysplasia
34 or neoplasia¹⁹; and
35

36 Whereas, Co-testing refers to screening with both primary screening and cytology¹⁹; and
37

38 Whereas, The use of a liquid-based, thin layer preparation technique for HPV cytology over
39 conventional preparation techniques allows for dual testing of HPV to gather further information
40 about cervical cancer risk²⁰; and
41

42 Whereas, Self-sampling is a type of primary screening where patients collect a vaginal sample
43 using various collection methods including tampon, brush, swag, lavage, or vaginal patch either
44 at home or at a clinic and then send those samples out to a third party for analysis¹⁰; and
45

46 Whereas, Self-sampling for HPV screening is not currently approved by the US Food and Drug
47 Administration (FDA)²¹; and
48

49 Whereas, In a systematic review of over 40 studies in the literature, a recent meta-analysis
50 found that pooled estimated sensitivity measuring cervical intraepithelial neoplasia (CIN) 2+ of
51 primary HPV testing, conventional cytology testing alone, or liquid-based cytology alone was

1 89.9%, 62.5%, and 72.9%, respectively, while the pooled specificity of the tests were 89.9%,
2 96.6%, and 90.3%, respectively²²; and

3
4 Whereas, The same study found that for detection of higher-grade CIN 3+, a comparison of
5 primary testing compared to conventional cytology found a relative sensitivity of 1.46 (95% CI:
6 1.12 to 1.91) and a relative specificity of 0.95 (95% CI, 0.93 to 0.97), while comparison of
7 primary hrHPV testing to liquid-based cytology in measuring CIN 3+ was found to have a
8 relativity sensitivity of 1.17 (95% CI, 1.07 to 1.28) and a relative specificity of 0.96 (95% CI: 0.95
9 to 0.97)²²; and

10
11 Whereas, In a meta-analysis of 36 studies, HPV testing on self-samples had a pooled sensitivity
12 of 76% (85%, CI 69-82) for CIN 2+ and 84% (95% CI, 72-92) for CIN 3+, while the pooled
13 specificity was 86% (95%, 83-89) and 87% (95%, 84-90) to exclude CIN 2+ and CIN 3+,
14 respectively²³; and

15
16 Whereas, Self-testing was found to have lower sensitivity and specificity in a comparison of
17 clinician-taken samples, with a ratio of 0.88 (95% CI, 0.85-0.91) for CIN 2+ and a ratio of 0.96
18 (95% CI, 0.95-0.97) for CIN 2+²³; and

19
20 Whereas, Studies have shown conflicting results regarding the sensitivity/specificity of self-
21 sampling compared to clinician-collected samples for HPV testing^{21,23,24}; and

22
23 Whereas, Primary HPV testing has been shown in several analyses to cause an increase in
24 detection of HPV and a decrease in cost burden to the healthcare system, and may be more
25 cost-effective than co-testing²⁵⁻³⁰; and

26
27 Whereas, Emerging international evidence, particularly from the United Kingdom, suggests, that
28 self-sampling for HPV may be a cost-effective approach for cervical cancer screening³¹⁻³³; and

29
30 Whereas, Compared to physician-administered testing, HPV self-sampling has been shown to
31 increase equity in cervical cancer screening by offering a greater reach to ethnic minority
32 women, sexual minority women, as well as women from lower socioeconomic backgrounds,
33 therefore helping to reduce disparities in cervical cancer screening³⁴⁻³⁷; and

34
35 Whereas, Traditional Medicaid includes mandatory family planning service benefits for
36 individuals of childbearing age, though it provides no formal definition for “family planning,”
37 leading to state-to-state variation in the services covered by this benefit³⁸; and

38
39 Whereas, While all states provide Medicaid coverage or public assistance programs for cervical
40 cancer screening, the Affordable Care Act (ACA) expanded Medicaid and in so doing creating a
41 new eligibility category which has federally-specified coverage requirements for family planning
42 (including screening services), but these new requirements do not apply to states with a
43 traditional Medicaid program only who have not expanded Medicaid³⁸; and

44
45 Whereas, For US citizens not eligible for Medicaid, the CDC also operates the National Breast
46 and Cervical Cancer Early Detection Program (AKA the Early Detection Program) to provide
47 cancer screening and diagnostic services to people who are low-income, uninsured, or
48 underinsured³⁹; and

49
50 Whereas, Medicare covers all possible screening options currently recommended by the AAFP,
51 ACS, ACOG, and USPSTF with the exception of primary HPV testing⁴⁰; and

1 Whereas, In their 2015 decision memo covering co-testing, the Center for Medicare and
2 Medicaid Services (CMS) acknowledged that ongoing studies were evaluating HPV for primary,
3 stand alone screening⁴¹; and
4

5 Whereas, AMA policy H-430.986 supports programs and staff training necessary to provide
6 gynecologic care for incarcerated women and adolescent females; and
7

8 Whereas, AMA policy H-440.872 supports HPV vaccination and cervical cancer prevention
9 worldwide and AMA Policy D-440.955 advocates for “the development of vaccine assistance
10 programs to meet HPV vaccination needs of uninsured and underinsured populations”;
11 therefore be it
12

13 RESOLVED, That our American Medical Association amend Policy H-440.872, HPV Vaccine
14 and Cervical Cancer Prevention Worldwide, by addition to read as follows:
15

16 **HPV Vaccine and Cervical Cancer Prevention Worldwide H-**
17 **440.872**

18 1. Our AMA (a) urges physicians to educate themselves and their
19 patients about HPV and associated diseases, HPV vaccination, as
20 well as routine HPV related cancer screening; and (b) encourages
21 the development and funding of programs targeted at HPV vaccine
22 introduction and HPV related cancer screening in countries without
23 organized HPV related cancer screening programs.

24 2. Our AMA will intensify efforts to improve awareness and
25 understanding about HPV and associated diseases in all individuals,
26 regardless of sex, such as, but not limited to, cervical cancer, head
27 and neck cancer, anal cancer, and genital cancer, the availability
28 and efficacy of HPV vaccinations, and the need for routine HPV
29 related cancer screening in the general public.

30 3. Our AMA:

31 (a) encourages the integration of HPV vaccination and routine
32 cervical cancer screening into all appropriate health care settings
33 and visits,

34 (b) supports the availability of the HPV vaccine and routine cervical
35 cancer screening to appropriate patient groups that benefit most
36 from preventive measures, including but not limited to low-income
37 and pre-sexually active populations,

38 (c) recommends HPV vaccination for all groups for whom the
39 federal Advisory Committee on Immunization Practices
40 recommends HPV vaccination.

41 4. Our AMA will encourage appropriate stakeholders to investigate
42 means to increase HPV vaccination rates by facilitating
43 administration of HPV vaccinations in community-based settings
44 including school settings.

45 5. Our AMA will study requiring HPV vaccination for school
46 attendance.

47 6. Our AMA encourages collaboration with stakeholders to provide
48 human papillomavirus vaccination to people who are incarcerated
49 for the prevention of HPV-associated cancers. (Modify Current
50 HOD Policy); and be it further

1 RESOLVED, That our AMA amend policy H-55.971, "Screening and
2 Treatment for Breast and Cervical Cancer Risk Reduction", by addition and
3 deletion to read as follows:

4
5 **Screening and Treatment for Breast and Cervical Cancer Risk**
6 **Reduction H-55.971**

7 1. Our AMA supports programs to screen all ~~women~~ individuals with
8 relevant anatomy for breast and cervical cancer and that
9 government funded programs be available for low income ~~women~~
10 individuals; the development of public information and educational
11 programs with the goal of informing all ~~women~~ individuals with
12 relevant anatomy about routine cancer screening in order to reduce
13 their risk of dying from cancer; and increased funding for
14 comprehensive programs to screen low income ~~women~~ individuals
15 for breast and cervical cancer and to assure access to definitive
16 treatment.

17 2. Our AMA encourages state and local medical societies to monitor
18 local public health screening programs to ensure that they are linked
19 to treatment resources in the public or private sector.

20 3. Our AMA encourages efforts by the Centers for Medicare and
21 Medicaid Services to evaluate and review their current cervical
22 cancer screening policies in an effort to expand coverage for HPV
23 testing including but not limited to in-office primary HPV testing.
24 (Modify Current HOD Policy); and be it further
25

26 RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-
27 sampling in the United States to determine whether it can decrease health care disparities in
28 cervical cancer screening. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

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 HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related 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,

(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,

(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.

5. Our AMA will study requiring HPV vaccination for school attendance.

Citation: Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22; Modified: Res. 916, I-22;

Screening for HPV-Related Anal Cancer H-460.913

Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.

Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Insurance Coverage for HPV Vaccine D-440.955

Our AMA:

(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;

(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and

(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Citation: Res. 818, I-06; Reaffirmed: CMS Rep. 01, 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; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

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; Modified: Res. 127, A-22;

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation’s correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19;

Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles D-60.994

Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse.

Citation: Res. 401, A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971

1. Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment.

2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

Citation: (CCB/CLRPD Rep. 3, A-14)

Screening for HPV-Related Anal Cancer H-460.913

Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.

Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Cancer and Health Care Disparities Among Minority Women D-55.997

Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.

Citation: Res. 509, A-08; Modified: CSAPH Rep. 01, A-18;

Quality of Pap Smear Analysis H-525.994

The AMA reaffirms its long-standing support of the Pap smear as an effective screening method for the detection of cervical cancer.

Citation: Res. 92, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.

2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.

3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.

4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in

receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

Citation: Alt. Res. 404, I-20; Appended: Res. 406, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-23)

Introduced by: Medical Student Section

Subject: Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972”
to Include Medical Professionals as a Party Who Can Petition the Court

Referred to: Reference Committee D

1 Whereas, Extreme Risk Protection Order (ERPO) laws and Red Flag laws stipulate that
2 parties such as law enforcement, family or household members, and/or intimate partners can
3 petition the court to temporarily remove firearms from a high risk individual through due
4 process¹; and
5

6 Whereas, An extreme risk individual is defined as an individual with severe mental illness
7 and/or who is at risk of harming themselves or others^{1,2}; and
8

9 Whereas, The Bipartisan Safer Communities Act passed by Congress in June 2022 allows
10 for Justice Assistance Grant (JAG) funding to be available to states who pass new ERPO
11 laws or improve existing ERPO laws³; and
12

13 Whereas, 19 states currently have ERPO/Red Flag laws; and in a White House meeting in
14 August 2022 representatives from Kentucky, Louisiana, Minnesota, New Hampshire, North
15 Carolina, Pennsylvania, and Texas shared plans for advancing new ERPO legislation
16 following the passage of the Bipartisan Safer Communities Act^{1,4}; and
17

18 Whereas, A study by Kivisto et al. (2018) showed that ERPO laws reduced suicide rates by
19 13.7% in Connecticut and 7.5% in Indiana; further Wintemute et al. (2019) evaluated 159
20 uses of California’s ERPO law and found 21 cases in which an ERPO was initiated after an
21 individual with access to firearms threatened a mass shooting, none of the threatened
22 shootings took place^{5,6}; and
23

24 Whereas, Only Hawaii, Maryland, Connecticut, New York and Washington, DC currently
25 include medical professionals as parties who can utilize ERPO laws, with Connecticut and
26 New York updating their ERPO laws to include this in June 2021 and June 2022
27 respectively^{1,7-10}; and
28

29 Whereas, In ERPO laws, “medical professionals” generally refers to licensed physicians,
30 physician assistants, advanced practice registered nurses, psychologists, counselors, and
31 social workers who have examined the individual^{9,11}; and
32

33 Whereas, In a Maryland study, surveyed physicians identified lack of knowledge about ERPO
34 laws as a barrier to physicians utilizing ERPO, and these same physicians asserted that this
35 barrier may be mitigated by increased training about ERPO laws¹²; and
36

37 Whereas, Since 2014, the ever-growing firearm epidemic has worsened, with the number of
38 mass shootings increasing from 273 per year in 2014 to 691 per year in 2021, the number of

1 deaths due to gun violence has increased from 12,418 people per year in 2014 to 19,411
2 people per year in 2020¹³; and

3
4 Whereas, The shooter in Buffalo New York in May 2022 was released without treatment, law
5 enforcement follow-up, or enactment of an ERPO following an evaluation by mental health
6 professionals, and following the shooting, New York updated its law to now include medical
7 professionals as a party able to file an ERPO^{7,14-16}; and

8
9 Whereas, Many states have mandatory or permissive Duty to Protect or Duty to Warn laws
10 for mental health professionals to report threats of imminent physical harm to other
11 persons^{17,18}; and

12
13 Whereas, Physicians, specifically those that treat persons at risk for suicide and intimate
14 partner violence, are highly trained to identify high-risk individuals based on symptoms,
15 behavioral patterns, and screening¹⁹⁻²²; and

16
17 Whereas, Medical professionals are encouraged to ask about firearm access during routine
18 patient visits which can help allow them to identify at risk individuals who may have access to
19 firearms²²; and

20
21 Whereas, HIPAA does not explicitly define firearm ownership as protected health information
22 (PHI), permitting disclosure in cases of public interest and benefit; and further in June 2021
23 the United States Department of Justice stated that disclosures of PHI are allowed in
24 compliance with ERPO laws when necessary to prevent imminent threats to the health and
25 safety of an individual and/or the public^{23,24}; and

26
27 Whereas, AMA policy H-145.972, Firearms and High Risk Individuals, describes the function
28 and process of ERPO/Red Flag laws but does not currently include medical professionals as
29 a party who can petition the court; and

30
31 Whereas, AMA policy H-145.976 supports creating state-specific guidance for physicians
32 about how to assess and act on risk of gun violence with patients within the scope of current
33 state law, but does not call for legislative change in those states; and

34
35 Whereas, AMA policy H-145.975 encourages physicians to work with families to reduce
36 patient access to lethal means when there is suicide risk but does not call for the passage of
37 laws to allow for physicians to act to reduce patient access to lethal means directly; therefore
38 be it

39
40 RESOLVED, That our American Medical Association work with relevant stakeholders to
41 develop state-specific training programs for medical professionals on how to use Extreme
42 Risk Protection Order/Red Flag Laws (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA work with relevant stakeholders to update medical curricula with
45 training surrounding how to approach conversations about Extreme Risk Protection
46 Order/Red Flag laws with patients and families (Directive to Take Action); and be it further

47
48 RESOLVED, That our AMA support amending policy "Firearms and High-Risk Individuals H-
49 145.972" by addition to read as follows:

1
2 Firearms and High-Risk Individuals H-145.972

3 Our AMA supports: (1) the establishment of laws allowing family
4 members, intimate partners, household members, and state,
5 federal, and tribal law enforcement personnel to petition a court
6 for the removal of a firearm when there is a high or imminent risk
7 for violence; (2) the establishment of laws and procedures
8 through which physicians and other medical professionals can,
9 in partnership with appropriate stakeholders, contribute to the
10 inception and development of such petitions; ~~(2)~~(3) prohibiting
11 persons who are under domestic violence restraining orders,
12 convicted of misdemeanor domestic violence crimes or stalking,
13 from possessing or purchasing firearms; ~~(3)~~(4) expanding
14 domestic violence restraining orders to include dating partners;
15 ~~(4)~~(5) requiring states to have protocols or processes in place for
16 requiring the removal of firearms by prohibited persons; ~~(5)~~(6)
17 requiring domestic violence restraining orders and gun violence
18 restraining orders to be entered into the National Instant
19 Criminal Background Check System; and ~~(6)~~(7) efforts to ensure
20 the public is aware of the existence of laws that allow for the
21 removal of firearms from high-risk individuals. (Modify Current
22 HOD Policy)
23

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

Received: 3/27/23

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RELEVANT AMA POLICY

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

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

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

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

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

4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18;

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

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

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

Citation: (Res. 410, A-13)

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

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

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

Citation: Res. 214, I-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.

4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Mental Health Crisis D-345.972

1. Our AMA will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:

- a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;
- b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
- c) Expand research into the disparities in youth suicide prevention;
- d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
- e) Develop and support resources and programs that foster and strengthen healthy mental health development; and
- f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.

2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.

Citation: Res. 425, A-22;

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in

youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;

- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
 - (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
 - (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
 - (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
 - (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
 - (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
- Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

Senior Suicide H-25.992

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

HIPAA Law And Regulations D-190.989

Our AMA shall: (1) continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care; and (2) continue to work with the appropriate parties and trade groups to explore ways to help offset the costs associated with HIPAA compliance so as to reduce the fiscal burden on physicians.

Citation: Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Reaffirmation: A-22; Modified: BOT Rep. 9, A-22;

Protection of Health Care Providers from Unintended Legal Consequences of HIPAA D-190.983

Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.

Citation: (Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)

Confidentiality and Privacy Protections Ensuring Care Coordination and the Patient-Physician Relationship H-315.964

Our AMA supports: (1) the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings; and (2) the sharing of substance use

disorder patient records as required by the HIPAA Privacy Rule and as applies to state law for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.

Citation: Res. 220, A-19;

Police, Payer and Government Access to Patient Health Information D-315.992

Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.

Citation: Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmation: A-22;

Data on Firearm Deaths and Injuries H-145.984

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

Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-23)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee D

1 Whereas, The American Disabilities Act defines “disability” as “a physical or mental
2 impairment that substantially limits one or more major life activities of such individual, a
3 record of such an impairment, or being regarded as having such an impairment”¹; and
4

5 Whereas, Adults with disabilities experience health disparities related to social determinants
6 of health, as they are less likely to have jobs with competitive wages, more likely to live in
7 poverty, and more likely to experience mental health issues²; and
8

9 Whereas, People with disabilities have been disproportionately affected by the COVID-19
10 pandemic, in terms of both health outcomes and economically, with unemployment rates that
11 are nearly double the unemployment rates of nondisabled people³⁻⁵; and
12

13 Whereas, One in five people with disabilities, or approximately one million people in the US,
14 lost their job during the COVID-19 pandemic, compared to one in seven people in the general
15 population⁶; and
16

17 Whereas, Between 2019 and 2020, the percentage of people with disabilities who were
18 employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in
19 employment from 66.3% to 61.8%⁷; and
20

21 Whereas, Almost half of unemployed disabled individuals endure barriers to employment,
22 while less than 10% of individuals with disabilities have been able to use career assistance
23 programs⁸; and
24

25 Whereas, Existing literature demonstrates that employment training programs are highly
26 beneficial for students with disabilities to gain competitive employment, and many have
27 success rates of 100% employment for their students^{2,9}; and
28

29 Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state
30 grants through the Department of Labor for employment and training services for people with
31 disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in
32 2018^{10,11}; and
33

34 Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist
35 students with disabilities through a transition from school to employment¹⁰; and
36

37 Whereas, In order to sustain the services provided to the community, Centers for
38 Independent Living (CIL) programs developed by the WIOA independently raised six times
39 the federal appropriation of funds in 2019, contributing to a 27% increase in utilization of
40 resources to assist with transition from youth to adult life²; and

1 Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic,
2 with community programs through WIOA reporting over 30% of employment service
3 programming closed due to COVID-19¹²; and
4

5 Whereas, The Arc, an organization that trains and employs thousands of individuals with
6 disabilities nationally, reported that employment programs have struggled during the COVID-
7 19 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or
8 furlough staff^{13,14}; and
9

10 Whereas, Section 188 of WIOA requires that employment services provide equal
11 opportunities for individuals with disabilities to participate in services and receive appropriate
12 accommodations; however, the COVID-19 pandemic has created disparities in receiving
13 these accommodations¹⁵; and
14

15 Whereas, AMA Policy H-90.967 encourages government agencies and other organizations to
16 provide psychosocial support for people with disabilities, but do not include employment
17 benefits; and
18

19 Whereas, As employment and socioeconomic status are social determinants of health closely
20 linked to health outcomes, increased resources for employment support programs would
21 provide equitable solutions for the drastic disparities that the COVID-19 pandemic has
22 created for people with disabilities¹⁶; therefore be it
23

24 RESOLVED, That our American Medical Association support increased resources for
25 employment services to reduce health disparities for people with disabilities. (New HOD
26 Policy)
27

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

Received: 3/31/23

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RELEVANT AMA POLICY

Support for Persons with Intellectual Disabilities H-90.967

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Citation: Res. 01, A-16;

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Citation: Res. 220, I-17;

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Citation: (Res. 705, A-13)

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

SSI Benefits for Children with Disabilities H-90.986

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.

Citation: (Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Support for Housing Modification Policies H-160.890

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Citation: Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-23)

Introduced by: Medical Student Section

Subject: Addressing Inequity in Onsite Wastewater Treatment

Referred to: Reference Committee D

1 Whereas, ‘Wastewater’ refers to any water that has been used for human activity, and is
2 most commonly produced through the everyday use of water by homes and businesses and
3 is contaminated with feces, urine, soaps, industrial wastes, and other organic matter, making
4 it unsuitable for reintroduction into the natural water supply¹; and

5
6 Whereas, In the United States, wastewater is often piped to centralized treatment facilities
7 where bulk products are strained, smaller pollutants are filtered or degraded, and biological
8 pollutants are disinfected, after which resultant water is fed into local watersheds²; and

9
10 Whereas, Exposure to inadequately treated wastewater may occur through occupational
11 exposure, breathing in wastewater-contaminated soil particles, or repeated ingestion of
12 wastewater-contaminated foods, and can lead to various illnesses including diarrheal
13 illnesses, helminth and trematode infections, and various skin disorders³⁻¹⁰; and

14
15 Whereas, Wastewater can also contain heavy metals like arsenic, mercury, lead, and
16 cadmium that can lead to diseases like cancer, cardiovascular disease, developmental
17 disorders, renal dysfunction, and osteoporosis, among others¹⁰⁻¹⁷; and

18
19 Whereas, There are clear disparities in access to adequate wastewater management
20 systems, with Tribal communities, communities of color, lower income communities, and rural
21 communities disproportionately having insufficient wastewater management systems¹⁸⁻²²; and

22
23 Whereas, In the United States, approximately 25% of residents do not have access to
24 underground sanitary sewers, which amounts to ~80 million people who must rely on onsite
25 wastewater treatment systems, otherwise known as septic tanks²³; and

26
27 Whereas, Because septic tanks are complex and expensive to install and require permitting
28 from the Environmental Protection Agency (EPA), houses and businesses in many poor rural
29 communities resort to using “straight pipe” sanitation systems wherein untreated toxic
30 wastewater is released directly into the environment²³⁻²⁶; and

31
32 Whereas, The prevalence of straight pipe sanitation systems means that hundreds of
33 thousands to millions of homes across the country are utilizing dangerous sewage systems
34 and could be releasing dangerous wastewater into nearby soil, lakes, or streams,
35 disproportionately in marginalized communities²⁷⁻²⁹; and

36
37 Whereas, Despite recent investment in wastewater management systems in the Bipartisan
38 Infrastructure Act of 2021, systemic underinvestment in wastewater management from
39 federal, state, and local governments has led to a projected deficit of \$1 trillion in funding by
40 2035^{30,31}; and

1 Whereas, Targeted research and investment by state governments into wastewater
2 treatment has yielded dividends, with efforts to implement improved agricultural and
3 stormwater management practices and build wastewater infrastructure from 2005 to 2013 in
4 North Carolina improved water quality in four stream segments by 2014, while price changes
5 and sewage system physical improvements such as pipe replacement and high-quality,
6 durable material usage led to a 12% decline in in-county sewage and a 41% decline in out-of-
7 county sewage in northern Georgia^{18,22,32}; and

8
9 Whereas, The Clean Water Act establishes the structure for regulating pollutant discharge
10 and maintaining water quality standards and requires that to discharge pollutants into a point
11 source, a person must obtain a permit through the National Pollutant Discharge Elimination
12 System (NPDES) and are subject to “a fine of not less than \$5,000 nor more than \$50,000
13 per day of violation, or by imprisonment for not more than three years, or both” for permit
14 violations³³; and

15
16 Whereas, Homes and businesses that use public “sanitary sewage” systems, including
17 straight pipe sanitation systems, do not need an NPDES permit and are regulated by their
18 local municipalities instead of by the EPA, indicating hundreds of thousands in the United
19 States use water treatment systems that are not regulated by the EPA and thus may be
20 releasing toxic wastewater into the environment^{24-26,33}; and

21
22 Whereas, Many state laws do not comprehensively address on-site wastewater management,
23 and those that do lack the flexible framework needed to support diverse communities³⁴; and

24
25 Whereas, Some states have provided local jurisdictions with additional regulatory power to
26 correct straight-pipe systems, such as a Minnesota law that allows municipalities to charge
27 \$500 per month to the owners of all straight-pipe systems not corrected after ten months of
28 non-compliance³⁵; and

29
30 Whereas, Some states have enacted programs to modernize and correct failed sewage
31 systems, but these programs are often underfunded, which the EPA has concluded leads to
32 continued contamination of local water systems^{36,37}; and

33
34 Whereas, When not paired with adequate funding to assist municipalities to transition to safer
35 wastewater management systems, punitive actions often fail to incentivize investments in
36 improved wastewater management, and instead place an undue burden on what are often
37 already struggling communities^{23,25}; and

38
39 Whereas, Innovative legislation like the Decentralized Wastewater Grant Act of 2020 which
40 established a grant program to allow low-income households to connect their homes to
41 existing wastewater infrastructures can provide communities affordable paths to make
42 necessary transitions to safer and more effective wastewater management systems, but are
43 insufficiently funded^{38,39}; therefore be it

44
45 RESOLVED, That our American Medical Association support that federal, state, and local
46 governments abate individual financial and criminal penalties for insufficient wastewater
47 management, especially those placed on underserved communities and American Indian
48 reservations due to environmental racism and socioeconomic disparities (New HOD Policy);
49 and be it further

- 1 RESOLVED, That our AMA support research by federal, state, and local governments to
2 develop strategies to reduce insufficient wastewater management and eliminate detrimental
3 health effects due to inadequate wastewater systems. (New HOD Policy)
4

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

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RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

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

Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-23)

Introduced by: Medical Student Section

Subject: School-to-Prison Pipeline

Referred to: Reference Committee D

1 Whereas, The School-to-Prison Pipeline is a term used to describe the biased application of
2 harsh disciplinary measures imposed on students which increases their likelihood of entering
3 the juvenile justice system^{1,2}; and
4

5 Whereas, The school-to-prison pipeline is a major public health issue that disproportionately
6 affects students of color, students from low-income household, and other vulnerable student
7 sub-groups, with Black students being suspended and expelled at a rate three times greater
8 than white students^{3,4,5}; and
9

10 Whereas, Male children who have moderate to severe food insecurity have an 11-fold increase
11 in suspension or expulsion, suggesting that the school-to-prison pipeline may be the result of
12 systematic health inequities rather than inherent behavioral issues with an individual child⁶; and
13

14 Whereas, Mixed-effects longitudinal models demonstrate that when controlling for
15 socioeconomic status, the odds of incarceration were 3.88 times greater for those who have
16 ever received a suspension as compared to those who have not⁷; and
17

18 Whereas, Zero tolerance policies historically stem from strict criminal punishments to tackle the
19 war on drugs in the 1980s and 1990s, but have now expanded into the education system with
20 intentions to reduce school disruptions^{1,2,8,9}; and
21

22 Whereas, The implementation of zero tolerances policies have resulted in an increased
23 presence of police in school, who may lack training in adolescent development, ultimately
24 leading to increases in the number of students arrested^{1,2,8,9}; and
25

26 Whereas, Students that are the victims of the discriminatory application of these policies are at
27 a greater risk for poor educational and health outcomes¹⁰⁻¹²; and
28

29 Whereas, Not addressing the underlying traumatic stress from these discriminatory practices
30 can perpetuate cycles of abuse, trauma, and incarceration, necessitating trauma-informed
31 physicians to mitigate these effects¹³⁻¹⁵; and
32

33 Whereas, The shift from a punitive system to a therapeutic, restorative, and individualized
34 approach has been recognized as the key towards ending the school-to-prison pipeline^{13,16-20};
35 and
36

37 Whereas, Implementing school-based restorative justice, which addresses student misconduct
38 through a positive and proactive systematic approach to underlying community issues, has
39 resulted in lower rates of absences and better academic outcomes^{13,17-19,21}; and

1 Whereas, Though our American Medical Association recently passed Student-Centered
2 Approaches for Reforming School Disciplinary Policies (H-60.900), it does not fully address the
3 causes and effects of the school-to-prison pipeline; therefore be it
4

5 RESOLVED, That our American Medical Association amend H-60.900 by addition to read as
6 follows:
7

8 **Student-Centered Approaches for Reforming School Disciplinary Policies**
9 **H-60.900**

10 Our AMA supports:

- 11 (1) evidence-based frameworks in K-12 schools that focus on school-wide
12 prevention and intervention strategies for student misbehavior; ~~and~~
13 (2) the consultation with school-based mental health professionals in the student
14 discipline process;
15 (3) efforts to address physical and mental trauma experienced by children in K-
16 12 education by reducing disproportionate punitive disciplinary actions and the
17 involvement of law enforcement in student discipline;
18 (4) transitions to restorative approaches that individually address students'
19 medical, social, and educational needs;
20 (5) ensuring that any law enforcement presence in K-12 schools focuses on
21 maintaining student and staff safety and not on disciplining students; and
22 (6) limiting the presence of law enforcement patrolling in schools to only those
23 settings and times where student and staff safety is at active risk. (Modify Current
24 HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
 2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
 3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
 4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
 5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
 6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.
- Citation: Alt. Res. 404, I-20; Appended: Res. 406, A-22;

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and (2) the consultation with school-based mental health professionals in the student discipline process.

Citation: Res. 008, A-22;

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Citation: Res. 404, A-17;

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; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

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; Modified: Res. 127, A-22;

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21;

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988

- (1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of

these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20;

Update on Tuberculosis H-440.931

It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.

Citation: (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

Citation: CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19;

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System H-80.994

Our AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system.

Citation: Sub. Res. 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

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;

AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16;

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.

Citation: CSAPH Rep. 01, A-20;

Use of the Choke and Sleeper Hold in Prisons H-430.998

The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.

Citation: (Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

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;

Police Chases and Chase-Related Injuries H-15.964

The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.

Citation: (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

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; (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; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.

Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22;

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919

Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

Citation: BOT Rep. 18, A-19;

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)

School Resource Officer Qualifications and Training H-60.902

Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Citation: Res. 926, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-23)

Introduced by: Medical Student Section

Subject: Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

Referred to: Reference Committee D

1 Whereas, Out-of-hospital cardiac arrest (OHCA) results from a sudden circulatory collapse
2 and it is fatal without rapid cardiopulmonary resuscitation (CPR) and/or defibrillation¹; and
3

4 Whereas, Bystander CPR is performed by a person who is not within the organized
5 emergency-response system, and has been identified as a necessary intervention to improve
6 out-of-hospital cardiac arrest survival²; and
7

8 Whereas, Every minute of delay in CPR results in a 10% decrease in survival rate, with
9 OHCA being responsible for over 350,000 deaths per year in the United States with an
10 estimated overall survival of 10%³⁻⁵; and
11

12 Whereas, Key strategies to improve survival include early recognition and activation of the
13 Emergency Response System, early CPR, rapid defibrillation and an increase in rates of
14 bystander CPR^{5,6}; and
15

16 Whereas, The American Heart Association (AHA) and supporting research recognize that
17 women are less likely than men to receive CPR or AED application from a bystander, and
18 even emergency medical services (EMS) are less likely to resuscitate women⁷⁻⁹; and
19

20 Whereas, Although OHCA rates are similar across genders, women have overall lower
21 survival rates following CPR intervention or hospital discharge, which may be due to
22 bystander hesitance to remove clothing items^{8,10,11}; and
23

24 Whereas, Concerns regarding accusations of sexual harassment or inappropriate touching,
25 discomfort with breasts, and fears of injuring women are commonly cited by the public,
26 particularly men, as reasons why women are less likely to receive bystander CPR in
27 instances of OHCA, though delays in CPR intervention have been found to be more costly
28 than concerns related to performing CPR^{12,13}; and
29

30 Whereas, While factors impacting CPR quality, such as clothing removal and hand
31 placement, are impacted by the sex of the CPR mannequin utilized in training, 98.4% of
32 almost 900 online CPR instructional videos use a male patient or mannequin without female
33 anatomy, and none discussed female-specific barriers to CPR or defibrillation^{10,14}; and
34

35 Whereas, A study of the diversity of mannequins used across North and Latin America found
36 only 12% were non-white, 6% represented women, <1% represented a non-lean body
37 habitus, and 1% represented pregnant individuals¹⁵; and
38

39 Whereas, While CPR intervention during pregnancy does not differ from standard CPR
40 intervention other than manual left uterine displacement, studies show higher maternal

1 mortality rates due to hesitancy of performing CPR due to concerns of inflicting harm on the
2 patient¹⁶; and

3
4 Whereas, In a 2022 study performed in Australia, provider confidence for performing CPR on
5 individuals with physical disabilities or abnormal chest shape was significantly improved by a
6 supplemental training course¹⁷; and

7
8 Whereas, Though The International Liaison Committee on Resuscitation (ILCOR)
9 recommends a depth of between 5cm and 6cm for adult chest compressions, the optimal
10 chest compression depth recommended by ILCOR is unlikely to be sufficient when
11 performing CPR on a patient with obesity¹⁸⁻²⁰; and

12
13 Whereas, Patients with body mass index classifications of “obese” or “underweight” are
14 associated with higher rates of in-hospital mortality following out of hospital cardiac arrest²⁴;
15 and

16
17 Whereas, There are still health disparities in OHCA survival rates due to a lack of
18 competency in CPR and AED delivery for women, pregnant people, people with physical
19 disabilities, and people with obesity^{8,10,11,16,17,21}; and

20
21 Whereas, Options for increasing diversity of CPR mannequins include the utilization of
22 different skin colors, body types, and genders, or purchasing kits which can add breasts to a
23 “male” chested mannequin on which a bra can be attached¹⁵; and

24
25 Whereas, Current cost-effective methods to diversify primarily male CPR mannequins include
26 the Womanikin, an open-source design, or low-cost female accessory packs to add breasts
27 to existing mannequins, indicating that existing mannequins can be modified to address
28 current differences in OHCA survival following CPR intervention^{22,23}; and

29
30 Whereas, Options for CPR mannequins representing pregnant persons or persons with
31 physical disabilities are not widely available; and

32
33 Whereas, While 2020 American Heart Association guidelines for CPR and emergency
34 cardiovascular care states that it is reasonable to address barriers to bystander CPR for
35 female victims through educational training and public awareness efforts, it is clear additional
36 action needs to be taken in order to address the disparities noted in OHCA CPR
37 intervention²⁴; and

38
39 Whereas, Teaching materials used in American Heart Association Advanced Certified Life
40 Support (ACLS) training have previously been found to insufficiently reflect races and gender
41 at risk of requiring CPR²⁵; and

42
43 Whereas, AMA policy H-130.938 outlines guidelines for CPR training for the American public,
44 but it fails to address key healthcare inequities that exist in CPR education and intervention
45 among minority groups; therefore be it

46
47 RESOLVED, That our American Medical Association support use of diverse mannequins in
48 CPR and AED training, including, but not limited to, mannequins with breasts, mannequins
49 representing pregnant persons, mannequins representing persons with disabilities, and
50 mannequins of varying body sizes (New HOD Policy); and be it further

1 RESOLVED, That our AMA support the efforts of relevant stakeholders to develop diverse
2 mannequins or modify current mannequins to reflect diverse patient populations, including,
3 but not limited to, those representing pregnant persons or persons with physical disabilities
4 (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA collaborate with relevant stakeholders to increase accessibility of
7 CPR and AED training equipment representing diverse gender and body types in basic life
8 support and advanced certified life support programs nationwide to ensure optimal
9 competency for trainees of all education levels. (Directive to Taker Action)
10

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

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
- (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945

Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.

Citation: CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 1, A-22;

E-8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
 - (b) Avoid stereotyping patients.
 - (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
 - (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
 - (e) Encourage shared decision making.
 - (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
- The medical profession has an ethical responsibility to:
- (g) Help increase awareness of health care disparities.
 - (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
 - (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Inclusion of Women in Clinical Trials H-525.991

Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice.

Citation: Res. 183, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 05, A-16; Reaffirmed: Res. 909, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-23)

Introduced by: Medical Student Section

Subject: Formal Transitional Care Program for Children and Youth with Special Health Care Needs

Referred to: Reference Committee D

1 Whereas, Children and youth with special health care needs (CYSHCN) are those whose
2 health care needs are more complex and require specialized care for their physical,
3 behavioral, or emotional development beyond that required by children generally¹; and
4

5 Whereas, “Special health care needs” include any chronic conditions, such as cystic fibrosis,
6 cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health
7 conditions^{1,2}; and
8

9 Whereas, Almost 20% of children between 12 and 18 years of age have a special health care
10 need³; and
11

12 Whereas, People with disabilities are described as having an activity limitation or who use
13 assistance or perceive themselves as having a disability⁴; and
14

15 Whereas, Most of CYSHCN do not fall under the formal definition of “disabled”⁴; and
16

17 Whereas, 90% of CYSHCN, who previously faced high rates of childhood mortality, now
18 increasingly survive to adulthood due to advances in medicine and therefore need the
19 appropriate care they received as children and young adults⁵; and
20

21 Whereas, Pediatric practices do not routinely start planning for transition to adult care until
22 the patient is around 18 years of age, and many pediatric practices do not have the available
23 policies, plans, or educational materials for a proper transition⁶; and
24

25 Whereas, Adult clinicians often do not have the specific infrastructure, education, and training
26 to care for young adults with pediatric-onset conditions⁷; and
27

28 Whereas, Research demonstrates that CYSHCN currently are inadequately supported during
29 the transition from pediatric to adult health care⁶⁻⁹; and
30

31 Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is
32 associated with decreased medication adherence, decreased patient engagement, increased
33 avoidable hospitalization, and other health risks like permanent end-organ damage and even
34 early death^{8, 10}; and
35

36 Whereas, The transition to adult services occurs during a developmental period marked by
37 increased risky behavior, emphasizing the need for stability and clear planning to promote
38 good outcomes and continued treatment adherence¹¹; and

1 Whereas, The ability of pediatricians and adult clinicians to communicate effectively during
2 the transition to adult care results in better health outcomes for the individual¹²; and
3

4 Whereas, The American Academy of Pediatrics, the American Academy of Family
5 Physicians, and the American College of Physicians have released and reaffirmed a
6 consensus statement supporting high-quality, planned transitions of care for all youth,
7 especially CYSHCN¹³; and
8

9 Whereas, The American Academy of Pediatrics has published a clinical report that
10 establishes an algorithm and set of guidelines (the “Transitional Clinical Report and
11 Algorithm”) to support the transition from adolescence to adulthood in the clinical home¹³; and
12

13 Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report
14 and Algorithm was published, some effective models of transition systems were made by
15 reputable organizations, like National Standards for CYSHCN, but none have been nationally
16 established^{13,14}; and
17

18 Whereas, Current AMA policy encourages physicians to establish transitional care programs
19 for children with disabilities (H-60.974), but existing language is not inclusive of all children
20 with special health care needs¹⁶; therefore be it
21

22 RESOLVED, That our American Medical Association amend policy H-60.974, *Children and*
23 *Youth with Disabilities*, by addition and deletion to read as follows, to strengthen our AMA
24 policy and to include a population of patients that do not fall under “disability” but also need
25 extra care, especially when transitioning to adult health care, that they are currently not
26 receiving due to a gap:
27

28 **Children and Youth with Disabilities and with Special**
29 **Healthcare Need H-60.974**

30 It is the policy of the AMA: (1) to inform physicians of the special health
31 care needs of children and youth with disabilities and children and youth
32 with special healthcare needs (CYSHCN);

33 (2) to encourage physicians to pay special attention during the preschool
34 physical examination to identify physical, emotional, or developmental
35 disabilities that have not been previously noted;

36 (3) to encourage physicians to provide services to children and youth with
37 disabilities and CYSHCN that are family-centered, community-based, and
38 coordinated among the various individual providers and programs serving
39 the child;

40 (4) to encourage physicians to provide schools with medical information
41 to ensure that children and youth with disabilities and CYSHCN receive
42 appropriate school health services;

43 (5) to encourage physicians to establish formal transition programs or
44 activities that help adolescents with disabilities, and CYSHCN, and their
45 families to plan and make the transition to the adult medical care system;

46 (6) to inform physicians of available educational and other local
47 resources, as well as various manuals that would help prepare them to
48 provide family-centered health care; and

1 (7) to encourage physicians to make their offices accessible to patients
2 with disabilities and CYSHCN, especially when doing office construction
3 and renovations. (Modify Current HOD Policy)
4

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

Received: 43/23

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RELEVANT AMA POLICY

Children and Youth With Disabilities H-60.974

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;

(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;

(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;

(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;

(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;

(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and

(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

Citation: CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaptation and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:

(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.

(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.

(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and

functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19;

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in

identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

- (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
- (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
- (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
- (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
- (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
- (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
- (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
- Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-23)

Introduced by: Medical Student Section

Subject: Protecting Workers During Catastrophes

Referred to: Reference Committee D

1 Whereas, Catastrophes are defined as critical situations, including but not limited to natural
2 disasters such as hurricanes, droughts, earthquakes, as well as pandemics and acts of war,
3 that endanger the lives, health, and/or safety of the population^{1,2}; and
4

5 Whereas, Natural disasters have injured more than 2 million people in the last 10 years³; and
6

7 Whereas, From 1992 to 2006, an estimated 72 occupational deaths in the United States were
8 associated with hurricanes and 62 deaths were associated with non-hurricane floods⁴; and
9

10 Whereas, In 2019, nearly 3.5 million workers across all industries had work-related injuries
11 and illnesses that were reported by employers, with 2.8 million injuries and illnesses reported
12 in private industry⁵; and
13

14 Whereas, The 2019 Workplace Safety Index estimated the cost of the most disabling
15 workplace injuries to employers at more than \$55 billion a year⁶; and
16

17 Whereas, Research shows that work-related injuries and illnesses are largely underreported⁷⁻
18 ⁹; and
19

20 Whereas, Between 2014 to 2017, Occupational Safety and Health Administration (OSHA)
21 investigated only a quarter of reported occupational deaths¹⁰; and
22

23 Whereas, Marginalized essential workers may be at increased risk of illness or injury during a
24 critical situation such as a pandemic due to the failure of their employer to provide basic
25 health safety protections¹¹; and
26

27 Whereas, Employer failure of enforcing safety precautions was exemplified on December 10,
28 2021, when Amazon workers were not sent home before a tornado struck the warehouse,
29 despite hours of notice that severe weather was imminent, which ultimately killed six people
30 and injured many others¹²; and
31

32 Whereas, While the tragedy was multifactorial, some of the causes included Amazon telling
33 employees they could not leave, not telling workers to stay home, and failing to provide
34 workers with adequate emergency training in preparation for natural disasters such as
35 tornadoes¹³; and
36

37 Whereas, Amazon not only has a history of discouraging workers from taking time off during
38 national disasters, but also as having policies that prohibit workers from carrying their phones
39 on warehouse floors, requiring them to leave them in vehicles or employee lockers before
40 passing through security checks that included metal detectors¹⁴; and

1 Whereas, The OSHA requires most businesses to have Emergency Action Plans, which
2 include evacuation procedures, but US law leaves it up to employers to decide whether to
3 send employees home in response to natural disasters¹⁵; and
4

5 Whereas, Even when there are OSHA violations but no violation of law, the penalty for
6 companies are on the order of thousands of dollars, which is an insignificant cost to multi-
7 billion dollar companies¹⁶; and
8

9 Whereas, Many of the federal workplace standards for emergency response and
10 preparedness are decades out of date, are not comprehensive, and do not consider the
11 effects of climate change¹⁴; and
12

13 Whereas, OSHA does not have requirements for hospitals to develop evacuation plans in
14 case of a hurricane or other extreme weather event even though OSHA has been
15 “considering updating these standards” since at least 2014^{4,17}; and
16

17 Whereas, Employees who refused to drive to work when conditions were potentially unsafe
18 but their employers did not deem conditions to be dangerous are not federally protected,
19 including under the National Labor Relations Act⁴; and
20

21 Whereas, The Environmental Protection Agency has projected that climate change will
22 continue to disproportionately impact underserved communities, affecting many who cannot
23 afford the threat of losing their jobs¹⁸; and
24

25 Whereas, Many states do not provide full protection of workers against retaliation or threat of
26 retaliation during public health emergencies resulting in employees to attend their place of
27 employment out of fear of termination¹⁹; and
28

29 Whereas, Current AMA policy around catastrophe preparedness revolves around the medical
30 field response (D-130.972 and H-130.992) and the effects of climate change on natural
31 disasters and affected communities (D-130.966, H-135.938 and H-135.973); and
32

33 Whereas, Our American Medical Association has limited policy advocating for the safety of
34 workers mainly focusing on heat exposure, with existing resolutions stating that the AMA will
35 work with United States Department of Labor, OSHA, and other appropriate federal
36 stakeholders to develop and enforce evidence-based policies, guidelines, and protections
37 against heat injury for workers (D-135.967); and
38

39 Whereas, Current AMA policy: 1. Does not address its support for protecting all forms of
40 workers during various catastrophes, especially regarding workers who are penalized for
41 taking appropriate safety precautions, 2. Does not address working with stakeholders to
42 develop policies about workers traveling during catastrophes (D-135.967); and
43

44 Whereas, The Occupational Safety and Health (OSH) Act requires employers to ensure a
45 safe workplace as outlined by a “duty of care” to protect their employees against an
46 unreasonable risk of harm; however, this policy is applied variably as evidenced by how
47 many workplace injuries and deaths are caused by catastrophes^{4,20,21}; therefore be it

1 RESOLVED, That our American Medical Association advocate for legislation that creates
2 federal standards of safety and protection of workers during natural or man-made
3 catastrophes (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA advocate that the United States Department of Labor, the
6 Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders
7 develop and enforce evidence-based policies, guidelines, and protections for workers at their
8 place of employment and traveling to and from their place of employment during
9 catastrophes. (Directive to Take Action)
10

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

Received: 4/3/23

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RELEVANT AMA POLICY

All Hazards Disaster Preparedness and Response D-130.972

Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.

Citation: (Res. 426, A-06; Reaffirmed in lieu of Res. 218, I-15)

Proposed Crisis Relocation and Shelter Plans H-130.992

Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude.

Citation: (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Workers' Compensation H-365.981

Our AMA:

- (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
- (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
- (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
- (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
- (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
- (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
- (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
- (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
- (9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
- (10) will continue activities to develop a unified body of policy addressing the medical care issues

associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

Citation: BOT Rep. X, A-93; Reaffirmed CMS Rep. 10, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: CMS na, A-17; Modified: CMS Rep. 01, A-17;

Advocating for Heat Exposure Protections for All Workers D-135.967

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.

Citation: Res. 502, I-21;

Development of a Federal Public Health Disaster Intervention Team H-130.942

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.
3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.

Citation: (BOT Rep. 3, A-07; Reaffirmed in lieu of Res. 218, I-15)

Fund for Public Health Emergency Response H-440.825

Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

Citation: Res. 420, A-16;

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full

integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification.

Citation: CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Bolstering Public Health Preparedness H-440.892

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.

Citation: Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19;

National Disaster Medical System H-130.979

The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency.

Citation: BOT Rep. Q, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

Farm-Related Injuries H-10.984

Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;

(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;

(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;

(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.

Citation: BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.

2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for

environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-23)

Introduced by: Medical Student Section

Subject: Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

Referred to: Reference Committee D

1 Whereas, In-install waste receptacles are a key feature in women’s restrooms across the
2 United States and are widely recognized to be an important part of maintaining a sanitary
3 public facility¹²; and
4

5 Whereas, Lack of in-install waste receptacles is a significant barrier to managing menstruation
6 safely and accessibly for transgender and nonbinary people¹⁰; and
7

8 Whereas, Thirty-one percent of transgender people who are out in places of public
9 accommodation experience negative treatment due to their gender identity, and some
10 transmasculine people fear changing their menstrual products in a public restroom may out
11 them^{2,6,10}; and
12

13 Whereas, Some transmasculine individuals’ physical appearance makes using the women’s
14 restroom more dangerous than using the men’s restroom in which menstrual product
15 receptacles are not universally available¹⁰; and
16

17 Whereas, Two-thirds of transmasculine people feel unsafe using the men’s restroom during
18 menstruation¹; and
19

20 Whereas, Fifty-nine percent of transgender people sometimes avoid public restrooms for fear
21 of confrontation and discrimination⁴; and
22

23 Whereas, Twelve percent of transgender people are verbally harassed in public restrooms
24 and one percent of transgender people are physically or sexually assaulted in public
25 restrooms⁴; and
26

27 Whereas, Nearly one-third of trans people have limited the amount they ate or drank in order
28 to avoid using the restroom⁶; and
29

30 Whereas, Poor menstrual hygiene has been linked to an increase in urinary and reproductive
31 tract infections and a long-term increase in infertility, and eight percent of transgender people
32 fight a urinary tract infection, kidney infection, or another kidney-related problem due to
33 avoiding restrooms^{5,6}; and
34

35 Whereas, Menstruating trans and nonbinary people sometimes hide used menstrual products
36 in their sleeves or pockets to avoid disposing of them in public and risking outing
37 themselves¹⁰; and
38

39 Whereas, Menstruation, gendered association with menstruation, and use of menstrual
40 products are sources of distress for many transgender people; and being forced to carry a

1 used menstrual product is dehumanizing and worsens the gender dysphoria and social
2 stigma that contributes to the forty-one percent suicide attempt rate for transgender
3 people^{1,3,9,13}; and
4

5 Whereas, Non-lined sanitary receptacles yield ten times more microbial contamination than
6 other bathroom surfaces, and thus hiding used menstrual products in pockets poses a
7 serious health threat⁸; and
8

9 Whereas, Non-hygienic handling of used menstrual products poses a serious health risk of
10 Hepatitis B and C exposure; and thus the U.S. Occupational Safety and Health
11 Administration (OSHA) requires sanitary disposal bins be lined by a plastic or wax bag and
12 workers be provided gloves to prevent physical contact with used menstrual products^{7,8}; and
13

14 Whereas, Transgender people may still be accommodated within existing binary restrooms in
15 places that lack gender-neutral restrooms for such reasons as cost-prohibitiveness and
16 building structure¹⁰; and
17

18 Whereas, The American Medical Association has a history of advocating for people to use
19 the restroom that aligns with their gender identity¹¹; and
20

21 Whereas, AMA Policy H-65.964 advocates for policies that promote safe access to public
22 facilities, including restrooms, for transgender individuals, but does not include support for
23 interventions to make exclusionary binary restroom facilities more inclusive; therefore be it
24

25 RESOLVED, That our American Medical Association amend H-65.964 "Access to Basic
26 Human Services for Transgender Individuals" by addition and deletion to read as follows:
27

28 **Access to Basic Human Services for Transgender**
29 **Individuals H-65.964**

30 Our AMA (1) opposes policies preventing transgender individuals
31 from accessing basic human services and public facilities in line
32 with one's gender identity, including, but not limited to, the use of
33 restrooms; ~~and~~ (2) will advocate for the creation of policies that
34 promote social equality and safe access to basic human services
35 and public facilities for transgender individuals according to one's
36 gender identity, and (3) will advocate for the inclusion of waste
37 receptacles in all restrooms, including male designated stalls, for
38 safe and discreet disposal of used menstrual products by people
39 who menstruate. (Modify Current HOD Policy)
40

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

Received: 4/3/23

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RELEVANT AMA POLICY

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17;

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee D

1 Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical,
2 sexual, or psychological aggression committed by current or former partners, including but not
3 limited to stalking, sexual harassment, or sexual coercion^{1,2}; and
4

5 Whereas, 1 in 3 women and 1 in 4 men in the United States have experienced some form of
6 IPV, with increased rates of injury and rape reported in sexual and ethnic minority
7 populations^{3,4}; and
8

9 Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and
10 bisexual cisgender men report experiencing IPV compared to 35% and 29% of heterosexual
11 cisgender women and men, respectively⁵; and
12

13 Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4
14 times more frequently than individuals who do not self-identify with a sexual minority group⁵;
15 and
16

17 Whereas, National survey data from the Centers for Disease Control state that 53.8% of
18 multiracial women, 46% of American Indian women, and 43.7% of Black women have
19 experienced IPV, compared to 34.6% of non-Hispanic white women⁶; and
20

21 Whereas, Individuals who experience IPV are also more likely to become victims of other forms
22 of sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking^{7,8};
23 and
24

25 Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels
26 of societal stress, panic, and financial and emotional strain resulting from the COVID-19
27 pandemic⁹; and
28

29 Whereas, IPV has acute effects on physical and mental health, including injury, unintended
30 pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of
31 substance use disorders, and death by homicide^{10,11}; and
32

33 Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70%
34 increased risk for heart disease, and 80% increased risk for stroke¹²; and
35

36 Whereas, The healthcare-related costs due to IPV are estimated to be \$104,000 per female
37 victim and \$23,000 per male victim, totaling to \$5.8 billion annually^{13,14}; and

1 Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly \$3.6
2 trillion, which includes direct medical costs, lost productivity, the financing of criminal justice
3 proceedings, and replacement of lost or damaged property¹³; and
4

5 Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits,
6 long-term treatment of physical and emotional injuries, mental health conditions, and substance
7 use disorders, legal proceedings, childcare, and finding safety¹⁵; and
8

9 Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating
10 further reliance on the abuser for living expenses, childcare, and additional resources^{3,9,16}; and
11

12 Whereas, Close to 60% of IPV survivors report employment instability and job loss due to
13 violence-related reasons, including but not limited to stigma, workplace discrimination due to
14 negative physical and mental effects of IPV, propensity for recurrence of abuse, decreased
15 productivity, and frequent absences^{3,16}; and
16

17 Whereas, 67% of those who have experienced or are experiencing IPV state that interactions
18 with an abusive partner limited their ability to complete education or job training for future
19 career growth, resulting in over 17% leaving the workforce³; and
20

21 Whereas, On average, 83% of IPV survivors experience 7.2 days of lost productivity per month
22 at work, totaling in 8 million days each year, thereby decreasing their chances of earning raises
23 or promotions^{3,14}; and
24

25 Whereas, This loss in productivity and workforce attrition translates to an annual cost of over
26 \$9.3 billion to the United States¹⁴; and
27

28 Whereas, 55% of companies do not have, publicize, or provide training for a workplace
29 violence prevention policy offering protections in the event of IPV¹⁷; and
30

31 Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have
32 paid family and medical leave¹⁸; and
33

34 Whereas, The Family and Medical Leave Act of 1993 provides only eligible federal workers
35 unpaid leave for medical needs and does not include regulations for private-sector
36 employers¹⁹; and
37

38 Whereas, A lack of access to paid leave causes employers and workers to lose \$22.5 billion
39 annually in wages and profits²⁰; and
40

41 Whereas, Those who have experienced IPV remain more vulnerable to the detrimental
42 consequences of lost wages from limited opportunities for paid leave, due to inability to afford
43 daily costs of living and medical expenses^{18,20}; and
44

45 Whereas, 11 states, including the District of Columbia, have enacted legislation offering “safe
46 time provisions” that protect employees who are victims of IPV^{21,22}; and
47

48 Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context
49 of experienced violence, including but not limited to safe leave, protection from wrongful
50 termination, and legal assistance stipends in the event of court proceedings²¹; and

1 Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental,
2 and social healing from trauma relating to any form of violence, particularly IPV, stalking, and
3 sexual harassment by non-partners²²; and
4

5 Whereas, Violence-related safe leave is distinct from personal medical or family leave in that it
6 includes extended time for ensuring personal and familial safety from threat of abuse,
7 protection from premature or wrongful termination of employment, stipends for legal aid, and
8 connection to social work or supportive agencies that facilitate physical, mental, and social
9 recovery^{22,23}; and
10

11 Whereas, States, districts, and cities that have instituted paid or unpaid safe leave or paid
12 family and medical leave policies inclusive of safe time provisions, including Sonoma, Seattle,
13 New York, and Philadelphia, have not found negative economic effects, subsequent decreases
14 in pay for other employees, or increases in unemployment^{18,21,22}; and
15

16 Whereas, Over \$1.1 billion could be saved in emergency department visits through paid safe
17 leave since implementation increases job and financial security of those experiencing IPV while
18 decreasing dependence on the abuser²⁰; and
19

20 Whereas, The implementation of paid safe leave decreased turnover of employees and
21 healthcare costs for preventable conditions, simultaneously improving productivity and
22 economic growth^{20,24}; and
23

24 Whereas, Survivors of IPV who had access to paid leave were better able to connect to family
25 court, had increased job security, and retained greater protection against recurrence of any
26 harassment or abuse by current, former, or non-partners^{1,25}; and
27

28 Whereas, Our AMA has policy (H-515.965) encouraging physicians to campaign against IPV
29 and violence in all forms; and
30

31 Whereas, Though our AMA has individual policies on family, medical, and sick leave (H-
32 420.979, H-440.823), it lacks policy supportive of providing adequate time for the physical,
33 emotional, and psychiatric healing required following an experience of IPV or non-partner
34 sexual violence; therefore be it
35

36 RESOLVED, That our American Medical Association recognize the positive impact of paid safe
37 leave on public health outcomes and support legislation that offers safe leave (New HOD
38 Policy); and be it further
39

40 RESOLVED, That our AMA amend the existing policy H-420.979, "AMA Statement on Family
41 and Medical Leave to promote inclusivity" by addition to read as follows:
42

43 **AMA Statement on Family and Medical Leave, H-420.979**

44 Our AMA supports policies that provide employees with reasonable job security
45 and continued availability of health plan benefits in the event leave by an
46 employee becomes necessary due to documented medical conditions and/or
47 concerns for safety. Such policies should provide for reasonable periods of paid
48 or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity
49 leave for the employee-mother; (3) leave if medically appropriate to care for a
50 member of the employee's immediate family, i.e., a spouse or children; ~~and~~ (4)
51 leave for adoption or for foster care leading to adoption; and (5) safe leave
52 provisions for those experiencing any instances of violence, including but not

1 limited to intimate partner violence, sexual violence or coercion, and stalking.
2 Such periods of leave may differ with respect to each of the foregoing
3 classifications, and may vary with reasonable categories of employers. Such
4 policies should encourage voluntary programs by employers and may provide for
5 appropriate legislation (with or without financial assistance from government).
6 Any legislative proposals will be reviewed through the Association's normal
7 legislative process for appropriateness, taking into consideration all elements
8 therein, including classifications of employees and employers, reasons for the
9 leave, periods of leave recognized (whether paid or unpaid), obligations on return
10 from leave, and other factors involved in order to achieve reasonable objectives
11 recognizing the legitimate needs of employees and employers. (Modify Current
12 HOD Policy)

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

Received: 4/3/23

The topic of this resolution is currently under study by the Council on Medical Education.

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

- (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
- (b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
- (c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
- (5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
- (6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
- (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
- (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
- (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
- (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
- (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Citation: CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19;

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; ; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22;

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

Citation: CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19;

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.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges 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.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

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 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 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 will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, 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.
 8. Residency programs should develop written policies on 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) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) 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; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
 9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. 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) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
 10. 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.
 11. 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.
 12. 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.
 13. 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.
 14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
 15. 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.
 16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
 17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
 18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
- Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-23)

Introduced by: Medical Student Section

Subject: Increased Access to HIV Treatment and Supportive Services in the Unstably
Housed and Homeless Population

Referred to: Reference Committee D

- 1 Whereas, Over three percent of people experiencing homelessness in the United States are
2 considered HIV--positive, compared to 1.8% of the stably housed population¹; and
3
- 4 Whereas, The San Francisco AIDS Foundation reported in 2017 that less than thirty-five
5 percent of HIV patients experiencing homelessness are considered to be virally suppressed,
6 and an observational study from 2014-2019 found that in Tennessee, patients who were
7 homeless were half as likely to achieve viral suppression compared to those who had a
8 permanent/stable home²⁻⁴; and
9
- 10 Whereas, According to an interventional study of HIV positive patients, lack of viral suppression
11 in homeless populations leads to a 63% increase in viral load and decreased CD4 count,
12 increased progression to AIDS, and increased HIV-related deaths⁵; and
13
- 14 Whereas, According to the Centers for Disease Control, viral suppression through the use of
15 antiretroviral therapy decreases an HIV-positive individual's viral load, improves immune
16 function against HIV, and prevents viral transmission to others through mechanisms such as
17 sexual exposure or sharing of syringes^{6,7}; and
18
- 19 Whereas, Increased viral suppression can reduce the transmission of HIV by more than 96%
20 while improving immune function and lowering the risk of AIDS- and non-AIDS-defining
21 complications¹; and
22
- 23 Whereas, Longitudinal studies identify lack of housing as a predictor of decreased continuity of
24 treatment among HIV-seropositive patients^{1,2}; and
25
- 26 Whereas, Lack of stable access to clean water, refrigeration, and proper nutrition can impair
27 adherence to antiretroviral treatments that require daily regimen^{8,9}; and
28
- 29 Whereas, The AIDS Drug Assistance Program (ADAP) provides FDA-approved medications
30 annually to half a million people with HIV who have limited or no health insurance^{10,11}; and
31
- 32 Whereas, According the ADAP directory, there are only thirty-two AIDS drug assistance
33 program locations nationwide, primarily in densely populated regions¹²; and
34
- 35 Whereas, Information about ADAP locations is accessible to the public via an online directory,
36 which may not be easily accessible to people experiencing homelessness due to lack of stable
37 internet access¹⁰⁻¹²; and

1 Whereas, Housing Opportunities for Persons With AIDS (HOPWA) is the only federal program
2 that provides housing opportunities for low income and homeless patients with HIV/AIDS¹²; and
3

4 Whereas, According to the HOPWA eligibility requirements, HOPWA considers itself a
5 competitive program¹⁴; and
6

7 Whereas, While individuals experiencing homelessness are able to apply for HOPWA grants,
8 the majority of grants are given to city or state governments with priority given to large
9 metropolitan areas¹⁴; and
10

11 Whereas, HOPWA's focus on increasing housing in metropolitan areas limits housing
12 opportunities for people experiencing homelessness in rural locations across the nation^{13,14}; and
13

14 Whereas, A 2016-2017 CDC analysis stated that Alabama, Arkansas, Kentucky, Mississippi,
15 Missouri, Oklahoma, and South Carolina have higher burdens of HIV cases in counties that are
16 considered rural¹⁵; and
17

18 Whereas, Stable housing provides HIV patients with increased access to care and consistency
19 of treatment regimens, increasing the likelihood of achieving viral suppression^{2,8,11,13}; and
20

21 Whereas, Existing AMA policy seeks to combat the HIV epidemic by encouraging the
22 development of educational interventions regarding HIV transmission (H-20.903), recognizing
23 the need for interventional measures that limit the transmission of HIV (H-20.922), supporting a
24 strategy to increase HIV testing, prophylaxis, and prevention (H-20.896), recognizing the urgent
25 need to reduce the transmission of HIV (H-20.907), and supporting increased financial care for
26 HIV patients (H-20.907), though no such policy exists to specifically address the need for
27 increased access to antiretroviral therapy and stable housing opportunities for people
28 experiencing homelessness; therefore be it
29

30 RESOLVED, That our American Medical Association support the development of regulations
31 and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs
32 (New HOD Policy); and be it further
33

34 RESOLVED, That our AMA recognize that stable housing promotes adherence to HIV treatment
35 (New HOD Policy); and be it further
36

37 RESOLVED, That our AMA amend current policy H-20.922, "HIV/AIDS as a Global Public
38 Health Priority" by addition and deletion to read as follows:
39

40 **HIV/AIDS as a Global Public Health Priority H-20.922**

41 In view of the urgent need to curtail the transmission of HIV infection in every
42 segment of the population, our AMA:

43 (1) Strongly urges, as a public health priority, that federal agencies (in
44 cooperation with medical and public health associations and state governments)
45 develop and implement effective programs and strategies for the prevention and
46 control of the HIV/AIDS epidemic;

47 (2) Supports adequate public and private funding for all aspects of the HIV/AIDS
48 epidemic, including research, education, ~~and~~ patient care, and access to stable
49 housing for the full spectrum of the disease. Public and private sector prevention
50 and care efforts should be proportionate to the best available statistics on HIV
51 incidence and prevalence rates;

- 1 (3) Will join national and international campaigns for the prevention of HIV
- 2 disease and care of persons with this disease;
- 3 (4) Encourages cooperative efforts between state and local health agencies, with
- 4 involvement of state and local medical societies, in the planning and delivery of
- 5 state and community efforts directed at HIV testing, counseling, prevention, and
- 6 care;
- 7 (5) Encourages community-centered HIV/AIDS prevention planning and
- 8 programs as essential complements to less targeted media communication
- 9 efforts;
- 10 (6) In coordination with appropriate medical specialty societies, supports
- 11 addressing the special issues of heterosexual HIV infection, the role of
- 12 intravenous drugs and HIV infection in women, and initiatives to prevent the
- 13 spread of HIV infection through the exchange of sex for money or goods;
- 14 (7) Supports working with concerned groups to establish appropriate and uniform
- 15 policies for neonates, school children, and pregnant adolescents with HIV/AIDS
- 16 and AIDS-related conditions;
- 17 (8) Supports increased availability of antiretroviral drugs and drugs to prevent
- 18 active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it
- 19 further; and
- 20 (9) Supports programs raising physician awareness of the benefits of early
- 21 treatment of HIV and of "treatment as prevention," and the need for linkage of
- 22 newly HIV-positive persons to clinical care and partner services. (Modify Current
- 23 HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

HIV/AIDS and Substance Abuse H-20.903

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

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) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- (5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (7) 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;
- (8) 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;
- (9) 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;
- (10) (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
- (11) 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;
- (12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other

stakeholders related to the needs of housing-insecure individuals.

(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

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; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17;

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy, and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19;

Financing Care for HIV/AIDS Patients H-20.907

Our AMA:

- (1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;
- (2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;
- (3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient

care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;

(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;

(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;

(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;

(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;

(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.

Citation: (CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Health Equity in Federally Subsidized Housing

Referred to: Reference Committee D

1 Whereas, In the 1980s, the government passed legislation known as the Comprehensive
2 Environmental Response, Compensation and Liability Act of 1980 (CERCLA) to assist the
3 Environmental Protection Agency (EPA) in identifying and remediating the country's most
4 dangerously contaminated sites by setting aside a 'Superfund' of money¹; and
5

6 Whereas, The Superfund set aside by CERCLA went bankrupt in 2003 leaving cleanup and
7 remediation projects, with estimated costs of \$15-100 million, to be funded solely through tax
8 revenue²; and
9

10 Whereas, Supreme Court rulings starting in 2008 with *Burlington Northern v. the United*
11 *States* have severely reduced the financial liability of polluters, stalling funding for the
12 Superfund program²; and
13

14 Whereas, CERCLA defines hazardous substances as elements and compounds which
15 present an imminent and substantial danger to the public health and welfare of living
16 creatures and waterfronts¹; and
17

18 Whereas, Hazardous substances defined by CERCLA include but are not limited to lead,
19 hexavalent chromium, radium, and polychlorinated biphenyl chemicals (PCBs), are known
20 hazards to human health, causing intellectual and behavioral delays, anemia, lung disease,
21 inflammatory diseases, cancers, adverse effects on fertility, and prenatal development³⁻⁶; and
22

23 Whereas, The geographic areas identified through CERCLA contaminated with known
24 hazardous substances are commonly referred to as Superfund sites¹; and
25

26 Whereas, As of 2020, 73 million people (22% of the US population) lives within 3 miles of a
27 Superfund site⁷; and
28

29 Whereas, Proximity to environmental hazards increases the risk for lifelong chronic mental
30 and physical illnesses, including but not limited to cancer, congenital disabilities, and
31 developmental disabilities⁹; and
32

33 Whereas, In Texas, East Houston's Fifth Ward, a community with proximity to three
34 Superfund sites, there is a pediatric and adult cancer cluster with 43 percent of households
35 reporting a cancer diagnosis¹⁰; and
36

37 Whereas, According to an evaluation performed by the Office of Inspector General in 2019,
38 18,158 properties owned, subsidized, or managed by the Department of Housing and Urban
39 Development (HUD) are located within one mile of Superfund sites¹¹; and

1 Whereas, The majority of people living in federally subsidized housing belong to racial and
2 ethnic minority groups, subjecting these groups to a disproportionate amount of
3 environmental hazards exposure leading to inequitable health outcomes⁸; and
4

5 Whereas, Neither the EPA, the Department of Housing and Urban Development, states,
6 cities, nor realtors are obligated to disclose proximity to Superfund sites upon purchase or
7 lease agreement leaving citizens unaware of the health hazards they and their children face
8 until they are grappling with long-term consequences¹²; and
9

10 Whereas, Those who rent their home are significantly less likely than homeowners to know
11 that they live in close proximity to Superfund sites¹³; and
12

13 Whereas, There is often a disconnect between environmental protection organizations and
14 community members near superfund sites, with residents of nearby communities often
15 lacking adequate knowledge to assess the environmental hazards around them¹⁴; and
16

17 Whereas, A potential strategy for mitigating the lack of community knowledge of
18 environmental exposures is to put communication processes in place to anticipate the
19 potential for disconnect and seek regular feedback from community members¹⁴; and
20

21 Whereas, The Residential Lead-Based Paint Hazard Reduction Act of 1992 establishes
22 guidelines to “educate the public concerning the hazards and sources of lead-based paint
23 poisoning and steps to reduce and eliminate such hazards”, demonstrating that the
24 precedent for hazardous substance disclosure has already been established¹⁵; and
25

26 Whereas, The disclosures described in the Residential Lead-Based Paint Hazard Reduction
27 Act of 1992, which include the explicit disclosure of lead-based paint in the property, a
28 warning statement signed by both purchaser and seller, and a lead hazard information
29 packet, do not extend to other environmental hazards which may be present at each site¹⁵;
30 and
31

32 Whereas, The “right to know” principle applied to public health ethics allows for individual
33 autonomy in decision making with respect to awareness of environmental hazard exposure¹⁶;
34 and
35

36 Whereas, Disclosure of known environmental health risks would promote informed decision-
37 making supporting individual autonomy¹⁶; and
38

39 Whereas, Environmental health-related care includes but is not limited to blood hazardous
40 substance screening, fertility, and prenatal testing, pediatric cognitive and behavioral delays
41 screening, and prescriptions for heavy metal chelating drugs^{3-5,9}; and
42

43 Whereas, Planning and execution of a Superfund site cleanup may take years to decades as
44 evidenced by the over 1,800 Superfund sites, as of January 4, 2022, that have been marked
45 for clean-up for decades without completed remediation^{12,17}; and
46

47 Whereas, Communities residing on or near Superfund sites may have to wait years even
48 after a clean-up project has been initiated for the toxin levels in their environment to reach
49 levels acceptable for residential use¹⁷; and

1 Whereas, Although the EPA and community organizations work to remediate the Superfund
2 sites fully, the EPA admits some sites may never reach environmental toxin levels safe for
3 residential use¹⁸; and
4

5 Whereas, Under CERCLA, the EPA maintains the right to establish Alternate Concentration
6 Limits (CLs) for use in Superfund cleanups that may fall below the standards of widely used
7 pollutant limits¹⁸; and
8

9 Whereas, The EPA maintains the right to waive violations of other state and federal
10 regulations on toxin levels due to “technical infeasibility” in order to approve a Superfund
11 cleanup¹⁸; and
12

13 Whereas, The current HUD-EPA agreement only requests yearly status reports on
14 contaminant levels and environmental indicators at active Superfund sites, subject to the
15 availability of the agency’s funding and manpower, and EPA guidelines suggest no follow-up
16 or follow-up monitoring only every five years at deleted Superfund sites^{12,19}; and
17

18 Whereas, Environmental justice is defined as the principle that all people and communities
19 regardless of race, color, national origin, or income, are entitled to equal protection by
20 environmental and public health laws and regulations, while environmental injustice
21 describes environmental laws, regulations and policies that overly affect a group of people
22 resulting in greater exposure to environmental hazards²⁰; and
23

24 Whereas, Environmental racism refers to a type of environmental injustice in which the racial
25 and ethnic contexts of environmental regulations and policies, exposures, support structures,
26 and health outcomes cause inequitable environmental hazards for some racial groups^{21,22};
27 and
28

29 Whereas, Low-income and minoritized communities are burdened by environmental injustice
30 in that they reside in areas with higher environmental exposures, reduced preventive
31 measures, and limited medical intervention, further exacerbating health outcome disparities²³⁻
32 ²⁷; and
33

34 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,
35 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial
36 segregation, exposed Black communities to environmental pollutants and targeting for
37 construction of toxin-releasing facilities, isolated them from essential health resources such
38 as healthy food options, hospitals, and green spaces, and permitted health inequities to
39 concentrate in disadvantaged low-income neighborhoods²⁸⁻³²; and
40

41 Whereas, The environmental justice and fair housing collaboration between the
42 Environmental Protection Agency (EPA) and U.S. Department of Housing and Urban
43 Development (HUD) remains inadequate due to insufficient action to provide non-
44 discriminatory and affordable housing units in locations without risk of environmental health
45 exposures³³; and
46

47 Whereas, A combination of inequitable land-use policies, lack of environmental regulation
48 and enforcement, and market forces in petrochemical and heavy metal industries have
49 contributed to the perpetuation of poverty and worse health outcomes in minoritized
50 populations³⁴; and

1 Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal
2 production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries
3 have been strongly linked to at least one of the following: neural tube defects, preterm birth,
4 low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation,
5 diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child
6 cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and
7 thyroid disease³⁵⁻⁴⁴; and
8

9 Whereas, Closures of industrial sites and reductions in pollution have been linked to
10 improved fertility and reduced preterm births and respiratory hospitalizations⁴⁵⁻⁴⁷; and
11

12 Whereas, The health of American Indian tribes depends on essential natural resources that
13 have either been depleted and/or contaminated by mining and oil corporations, leading to
14 adverse health outcomes⁴⁸⁻⁵¹; and
15

16 Whereas, Government agencies have failed to act on current policy and integrate current
17 environmental science research or expertise into ongoing environmental regulations and
18 public health initiatives, resulting in continued and amplified environmental hazards and
19 failing to protect people, especially in Black and American Indian communities, from known
20 and predictable environmental health dangers⁵²⁻⁵⁹; and
21

22 Whereas, Our AMA policy H-135.996 addresses the existence of environmental pollution and
23 supports research into its threat to human health; and
24

25 Whereas, Our AMA policy H-135.996 supports efforts to alert the American people to the
26 dangers of general environmental pollution, however, it does not go far enough to ask for
27 mandated disclosure to residents in known areas of environmental risk; and
28

29 Whereas, Our AMA policy H-135.996 does not directly address the need for expansion of
30 federally funded health insurance coverage of services to specifically address the health risk
31 associated with residing in or near polluted environments; and
32

33 Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat,
34 and has pledged to work to combat the adverse health effects of racism (H-65.952); therefore
35 be it
36

37 RESOLVED, That our American Medical Association acknowledge the potential adverse
38 health impacts of living in close proximity to a Superfund site (New HOD Policy); and be it
39 further
40

41 RESOLVED, That our AMA advocate for mandated disclosure of Superfund site proximity to
42 those purchasing, leasing, or currently residing in housing in close proximity to Superfund
43 sites (Directive to Take Action); and be it further
44

45 RESOLVED, That our AMA support efforts of public agencies to study the safety of proposed
46 public housing expansions with respect to pollutant exposure and to expand construction of
47 new public and publicly subsidized housing properties on lands without demonstrated unsafe
48 levels of hazardous pollutants (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend Policy D-135.997, "Research into the Environmental
2 Contributors to Disease," by addition and deletion to read as follows:
3

4 D-135.997 – ~~RESEARCH INTO THE ENVIRONMENTAL~~
5 CONTRIBUTORS TO DISEASE AND ADVOCATING FOR
6 ENVIRONMENTAL JUSTICE

7 Our AMA will (1) advocate for the greater public and private funding for
8 research into the environment causes of disease, and urge the National
9 Academy of Sciences to undertake an authoritative analysis of
10 environmental causes of disease; (2) ask the steering committee of the
11 Medicine and Public Health Initiative Coalition to consider environmental
12 contributors to disease and environmental racism as a priority public
13 health issues; (3) encourage federal, state, and local agencies to address
14 and remediate environmental injustice, environmental racism, and all
15 other environmental conditions that are adversely impacting health,
16 especially in marginalized communities; and ~~(34)~~ lobby Congress to
17 support ongoing initiatives that include reproductive health outcomes and
18 development particularly in minority populations in Environmental
19 Protection Agency Environmental Justice policies. (Modify Current HOD
20 Policy)
21

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

Received: 4/3/23

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RELEVANT AMA POLICY

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;
Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Modern Chemicals Policies H-135.942

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Citation: Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16;
Reaffirmed in lieu of: Res. 505, A-19;

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

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

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-23)

Introduced by: Medical Student Section

Subject: New Policies to Respond to the Gun Violence Public Health Crisis

Referred to: Reference Committee D

1 Whereas, Gun violence is a major public health crisis in the United States with the Centers
2 for Disease Control and Prevention (CDC) most recently reporting 45,222 gun-related deaths
3 in 2020—a 14% increase from 2019, and the most on record at the time and¹⁻³; and
4

5 Whereas, The CDC reported that gun-related injuries were one of the five leading causes of
6 death for people aged 1 to 44 in the U.S. in 2020³⁻⁴; and
7

8 Whereas, A May 2022 letter in *The New England Journal of Medicine* based on 2020 CDC
9 data suggests that gun-related injuries have surpassed motor vehicle crashes to now
10 become the leading cause of death for children and young adults aged 1 to 19³⁻⁴; and
11

12 Whereas, According to 2020 CDC data, over 40% of gun-related deaths were homicides
13 (19,384 deaths, or 79% of all homicides) and over 50% of gun deaths were suicides (24,292
14 deaths, or 53% of all suicides), accounting for 124 deaths a day³; and
15

16 Whereas, The Gun Violence Archive, an independent data research group that tracks gun-
17 related incidents and defines a mass shooting using a statistical threshold as an event where
18 four or more people are shot, reported 692 mass shootings in 2021 and 610 in 2020⁵⁻⁶; and
19

20 Whereas, The Gun Violence Archive reported that 246 mass shootings took place in the first
21 five months of 2022⁶; and
22

23 Whereas, On May 24, 2022, 21 children and teachers were killed and 18 injured at Robb
24 Elementary School in Uvalde, Texas, the second deadliest school shooting on record, ten
25 years after 26 students and educators were killed in the Sandy Hook Elementary shooting⁷;
26 and
27

28 Whereas, On June 1, 2022, two physicians, a patient, and another healthcare worker were
29 killed and several injured in a mass shooting at the St. Francis Hospital in Tulsa, Oklahoma⁸;
30 and
31

32 Whereas, Advocacy to address the gun violence public health crisis is crucial to support the
33 AMA's goals of promoting racial justice and health equity, as CDC data shows that Black,
34 American Indian and Alaska Native, and Hispanic people are disproportionately affected by
35 gun homicides compared to white individuals⁹; and
36

37 Whereas, Multiple countries, including the United Kingdom, New Zealand, Norway, and
38 Australia, quickly introduced and have adopted successful national legislation to ban semi-
39 automatic and automatic weapons after just a single mass shooting¹⁰; and

1 Whereas, Approximately 20-25% of all handguns recovered at crime scenes were originally
2 purchased as part of a multiple sale, which is the purchase of more than one gun within 5
3 business days¹¹; and
4

5 Whereas, Handguns sold in multiple sales are up to 64% more likely to be used in crime
6 scenes than handguns sold individually¹²; and
7

8 Whereas, Many jurisdictions do not require background checks for the purchase of
9 ammunition; however, research predicts that background checks for ammunition purchases
10 would cut gun-related death rates by 81%¹³; and
11

12 Whereas, Waiting period laws that delay the purchase of firearms by a few days reduce gun
13 homicides by roughly 17%¹⁴;and
14

15 Whereas, States have different firearm inheritance laws where it may be easier in some
16 states for individuals to obtain a firearm, such as some states require the firearm to be
17 registered while other states don't require a permit to own a firearm^{15,16}; and
18

19 Whereas, In 2020, our AMA announced a partnership with West Side United to invest \$6
20 million in community infrastructure programs in Chicago's west side neighborhoods to
21 address issues relating to health inequities and economic vitality based on community needs,
22 including affordable housing, access to healthy foods, financing local business projects, and
23 supporting job creation efforts and educational programs¹⁷; and
24

25 Whereas, In the wake of the Pulse Orlando mass shooting in 2016, our AMA declared gun
26 violence as a public health crisis "requiring a comprehensive public health response and
27 solution" yet the number of gun deaths have only continued to rise (D-145.995)¹⁸; and
28

29 Whereas, Our AMA has adopted numerous policies to reduce gun trauma, injury and death,
30 including H-145.996, H-145.975, H-145.997, D-145.996, H-145.983, H-145.978, H-145.984,
31 H-145.979, H-145.985, H-145.990, H-145.992, H-145.993, H-145.999, H-515.971, and
32 145.001MSS, but as this crisis continues to escalate, further advocacy is needed; therefore
33 be it
34

35 RESOLVED, That our American Medical Association advocate for federal and state policies
36 that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all
37 federal and state requirements for background checks, waiting periods, and licensure
38 (Directive to Take Action); and be it further
39

40 RESOLVED, That our AMA advocate for federal and state policies to prevent "multiple sales"
41 of firearms, defined as the sale of multiple firearms to the same purchaser within five
42 business days (Directive to Take Action); and be it further
43

44 RESOLVED, That our AMA advocate for federal and state policies implementing background
45 checks for ammunition purchases. (Directive to Take Action)

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

Received: 4/5/23

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RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

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

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

Citation: (Res. 216, A-15)

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

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

Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze

firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms, (3) advocate for improvements to the quality, comparability, and timeliness of data on firearm injuries and deaths, and (4) advocate for repeal of laws which prohibit the release of firearm tracing data for research.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18; Reaffirmed: Res. 907, I-22; Appended: Res. 921, I-22;

Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery H-10.960

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physicians in policy advocacy and counseling patients so as to decrease the risk of morbidity and mortality.

Citation: CSAPH Rep. 3, I-21;

Less-Lethal Weapons and Crowd Control H-145.969

Our AMA: (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.

Citation: BOT Rep. 10, A-21; Reaffirmed: BOT Rep. 2, I-21;

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

Citation: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Citation: Res. 212, I-18; Modified: Res. 934, I-19;

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;

(5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

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

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

Citation: Res. 214, I-16;

Increasing Toy Gun Safety H-145.974

Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

Citation: (Res. 406, A-15)

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.

5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.

6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.

7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal

means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

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

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

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

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

4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

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)

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Prevention of Unintentional Shooting Deaths Among Children H-145.979

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

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

Prevention of Ocular Injuries from BB and Air Guns H-145.982

The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.

Citation: Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Citation: Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15;
Appended: Res. 402, A-18;

Data on Firearm Deaths and Injuries H-145.984

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

Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
- (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
- (4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
- (5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18; Reaffirmation: I-22;

AMA Campaign to Reduce Firearm Deaths H-145.988

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

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

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

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

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

Prevention of Firearm Accidents in Children H-145.990

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

2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

Citation: Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18; Appended: Res. 923, I-22;

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18;

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Restriction of Assault Weapons H-145.993

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

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

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Citation: Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18; Modified: Res. 907, I-22;

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Citation: Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.

4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

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.

3. Our AMA will: (a) advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care; and (b) work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities.

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; Appended: Res. 404, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-23)

Introduced by: Senior Physicians Section

Subject: Treating Social Isolation and Loneliness as a Social Driver of Health

Referred to: Reference Committee D

- 1 Whereas, Social isolation and loneliness have been recognized as significant public health
2 concerns, with adverse impacts on physical and mental well-being, and quality of life¹; and
3
- 4 Whereas, Social isolation and loneliness are not only experienced by older adults but also affect
5 individuals across the lifespan, including young people, single parents, immigrants, and
6 individuals with disabilities; and
7
- 8 Whereas, Social isolation and loneliness are linked to a wide range of chronic diseases,
9 including cardiovascular disease, dementia, depression, and anxiety, and are associated with
10 increased morbidity and mortality; and
11
- 12 Whereas, Social isolation and loneliness can result from social and economic factors, including
13 poverty, inadequate housing, discrimination, and lack of access to healthcare and other
14 services, and can be exacerbated by emergencies and disasters such as pandemics²; and
15
- 16 Whereas, Social isolation and loneliness are shaped by structural factors that affect other social
17 determinants of health, including employment, education, and social policies that impact
18 housing, transportation, and community resources; therefore be it
19
- 20 RESOLVED, That our American Medical Association develop educational programs for
21 healthcare professionals and the lay public regarding the significance of social isolation and
22 loneliness to include promoting social connections through community-based programs and
23 encouraging social participation through volunteering, civic engagement, and community service
24 (Directive to Take Action); and be it further
25
- 26 RESOLVED, That our AMA promote enhancing access, including transportation, to health and
27 social services (Directive to Take Action); and be it further
28
- 29 RESOLVED, That our AMA encourage research to assess how forming networks earlier in life
30 helps to reduce loneliness and social isolation for adults, with a special focus on marginalized
31 populations and communities with limited access to resources (New HOD Policy); and be it
32 further
33
- 34 RESOLVED, That our AMA develop toolkits to help clinicians identify and address social
35 isolation and loneliness as a social driver of health (Directive to Take Action); and be it further
36
- 37 RESOLVED, That our AMA work collaboratively with state medical societies, community-based
38 organizations, social service agencies, and public health departments to promote social
39 connections and enhance social support for patients. (Directive to Take Action)

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

Received: 4/26/23

REFERENCES

1. National Academies of Sciences, Engineering, and Medicine. (2020). *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. National Academies Press.
2. Holt-Lunstad, J., & Perissinotto, C. (2023). Social Isolation and Loneliness as Medical Issues. *New England Journal of Medicine*.

RELEVANT AMA POLICY

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

1. Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
2. Our AMA: (a) will advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy; (b) adopts the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes; (c) will advocate for adequate standards and capabilities for electronic health records to effectively tag and protect sensitive data before it can be shared or reshared; and (d) supports ongoing monitoring and data collection regarding unintended harm to patients from sharing information on social determinants of health and social risk.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19; Appended: Res. 440, A-22;

Recognizing Loneliness as a Public Health Issue D-440.913

Our AMA: (1) will release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and (2) supports evidence-based efforts to combat loneliness.

Citation: Res. 432, A-22;

Senior Suicide H-25.992

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-23)

Introduced by: Medical Student Section

Subject: Increasing the Availability of Automated External Defibrillators

Referred to: Reference Committee D

- 1 Whereas, 18.8% of sudden cardiac arrests outside of the hospital occur in public spaces, and
2 70% of those sudden cardiac arrests in public spaces occur in residential complexes¹; and
3
- 4 Whereas, Laypersons witness 38.3% of cardiac arrest episodes that occur outside of the
5 hospital, and therefore they play a critical role in helping first responders address a cardiac
6 arrest¹; and
7
- 8 Whereas, Patients receiving an Automated External Defibrillator (AED) shock prior to
9 emergency medical service arrival resulted in 38% survival versus 9% survival in those who
10 only received cardiopulmonary resuscitation²; and
11
- 12 Whereas, When dispatchers instruct a bystander to locate an AED that is nearby, they are
13 seldom within obvious view, which can severely limit the application of the AED³; and
14
- 15 Whereas, The lack of AED accessibility is known as a major contributing factor to worse
16 health outcomes and is a barrier to increasing survival for out-of-hospital cardiac arrests
17 (OHCA)⁴; and
18
- 19 Whereas, One study in Howard County, Maryland reported a weak correlation between AED
20 location and witnessed OHCA sites, indicating that AEDs were not registered at sites with the
21 most OHCA occurrences⁵; and
22
- 23 Whereas, A study in Phoenix, Arizona found a weak correlation between sites where
24 incidents of OHCA took place and the number of AEDs available⁶; and
25
- 26 Whereas, AED-related disparate health outcomes present disproportionately in Black
27 neighborhoods, as shown by the fact that there was a positive correlation between cardiac
28 arrests in AED-unavailable public locations with higher numbers of Black residents⁷; and
29
- 30 Whereas, Black men and women in America have an incidence of out-of-hospital sudden
31 cardiac death at 2.8% and 2.3% compared to their White counterparts at 1.4% and 0.7%,
32 respectively⁸; and
33
- 34 Whereas, Currently our American Medical Association advocates for the widespread
35 placement of AED devices (H-130.938), but does not reference doing so in a targeted and
36 equitable manner that is necessary to speak to existing issues and disparities that a
37 generalized widespread distribution does not address; and
38
- 39 Whereas, Methodologies that take into account spatial and temporal data are needed to
40 determine placement of AEDs in areas that suffer from increased frequency of OHCA⁹; and

1 Whereas, Targeted placement of AEDs in areas with a high likelihood of sudden cardiac
2 arrest events has been shown to be cost effective, decrease time to defibrillation, and
3 increase odds of survival¹⁰⁻¹¹; and
4

5 Whereas, Optimizing the placement of AEDs in the public resulted in increased coverage of
6 OHCA in areas with greater disparities similarly to the way that doubling the amount of AEDs
7 would have done¹²; and
8

9 Whereas, Studies that utilized computational approaches to targeted placement of AEDs
10 provided an additional modality that confirms the optimization of AED access, improves
11 coverage and usage of AED devices, as well as increases survival in OHCA episodes¹³⁻¹⁴;
12 therefore be it
13

14 RESOLVED, That our American Medical Association amend Policy H-130.938,
15 “Cardiopulmonary Resuscitation (CPR) and Defibrillators,” by addition to read as follows:
16

17 **Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938**

18 Our AMA:

- 19 (1) supports publicizing the importance of teaching CPR, including the
20 use of automated external defibrillation;
- 21 (2) strongly recommends the incorporation of CPR classes as a voluntary
22 part of secondary school programs;
- 23 (3) encourages the American public to become trained in CPR and the
24 use of automated external defibrillators;
- 25 (4) advocates the widespread placement of automated external
26 defibrillators, including on all grade K-12 school campuses and locations
27 at which school events are held;
- 28 (5) encourages all grade K-12 schools to develop an emergency action
29 plan for sudden cardiac events;
- 30 (6) supports increasing government and industry funding for the purchase
31 of automated external defibrillator devices;
- 32 (7) endorses increased funding for cardiopulmonary resuscitation and
33 defibrillation training of community organization and school personnel;
- 34 (8) supports the development and use of universal connectivity for all
35 defibrillators;
- 36 (9) supports legislation that would encourage high school students be
37 trained in cardiopulmonary resuscitation and automated
38 external defibrillator use;
- 39 (10) will update its policy on cardiopulmonary resuscitation and
40 automated external defibrillators (AEDs) by endorsing efforts to promote
41 the importance of AED use and public awareness of AED locations, by
42 using solutions such as integrating AED sites into widely accessible
43 mobile maps and applications;
- 44 (11) urges AED vendors to remove labeling from AED stations that
45 stipulate that only trained medical professionals can use the defibrillators;
46 ~~and~~
- 47 (12) supports consistent and uniform legislation across states for the legal
48 protection of those who use AEDs in the course of attempting to aid a
49 sudden cardiac arrest victim; and.

- 1 (13) encourages the distribution of Automated External Defibrillators in an
2 equitable manner through the utilization of targeted placement strategies
3 in order to increase availability and decrease disparities in areas where
4 disproportionate rates of out-of-hospital cardiac arrest episodes exist.
5 (Modify Current HOD Policy)
6

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

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;

- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
 - (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
 - (8) supports the development and use of universal connectivity for all defibrillators;
 - (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
 - (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
 - (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
 - (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
- Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992

Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest.

Citation: Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System

Referred to: Reference Committee D

1 Whereas, Child, youth, and young adult suicide is the leading cause of death in this age group;
2 and
3

4 Whereas, Additional research has identified children, youths, and young adults within the
5 welfare system to be at higher risk of suicide than other age/race matched peers; and
6

7 Whereas, Our American Medical Association has policy regarding research into higher risk
8 individuals (H-60.937, *Youth and Young Adult Suicide in the United States*); therefore be it
9

10 RESOLVED, That our American Medical Association amend policy H-60.937, *Youth and Young*
11 *Adult Suicide in the United States*, by addition and deletion to read as follows:
12

13 **Youth and Young Adult Suicide in the United States H-60.937**

14 Our AMA:

- 15 1) Recognizes child, youth and young adult suicide as a serious health concern in
16 the US;
- 17 2) Encourages the development and dissemination of educational resources and
18 tools for physicians, especially those more likely to encounter child, youth or
19 young adult patients, addressing effective suicide prevention, including screening
20 tools, methods to identify risk factors and acuity, safety planning, and appropriate
21 follow-up care including treatment and linkages to appropriate counseling
22 resources;
- 23 3) Supports collaboration with federal agencies, relevant state and specialty
24 societies, schools, public health agencies, community organizations, and other
25 stakeholders to enhance awareness of the increase in child, youth and young
26 adult suicide and to promote protective factors, raise awareness of risk factors,
27 support evidence-based prevention strategies and interventions, encourage
28 awareness of community mental health resources, and improve care for children,
29 youth and young adults at risk of suicide;
- 30 4) Encourages efforts to provide children, youth and young adults better and more
31 equitable access to treatment and care for depression, substance use disorder,
32 and other disorders that contribute to suicide risk;
- 33 5) Encourages continued research to better understand suicide risk and effective
34 prevention efforts in children, youth and young adults, especially in higher risk
35 sub-populations such as those with a history of childhood trauma and adversity,
36 Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young
37 adult populations, and children in the welfare system;
- 38 6) Supports the development of novel technologies and therapeutics, along with
39 improved utilization of existing medications to address acute suicidality and
40 underlying risk factors in children, youth and young adults;

- 1 7) Supports research to identify evidence-based universal and targeted suicide
2 prevention programs for implementation in middle schools and high schools;
- 3 8) Will publicly call attention to the escalating crisis in children, youth and young
4 adult and adolescent mental health in this country in the wake of the Covid-19
5 pandemic;
- 6 9) Will advocate at the state and national level for policies to prioritize children's,
7 youth's, and young adult's mental, emotional, and behavioral health;
- 8 10) Will advocate for comprehensive system of care including prevention,
9 management, and crisis care to address mental and behavioral health needs for
10 infants, children, youth, and young adult and adolescents; and
- 11 11) Will advocate for a comprehensive approach to the child youth, and young adult
12 and adolescent mental and behavioral health crisis when such initiatives and
13 opportunities are consistent with AMA policy. (Modify Current HOD Policy)

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

Received: 5/2/23

RELEVANT AMA POLICY

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
- (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
- (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
- (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Foster Health Care

Referred to: Reference Committee D

1 Whereas, Our American Medical Association has established policy H-60.910, *Addressing*
2 *Healthcare Needs of Children in Foster Care*, delineating health care for children within the
3 foster care system; and
4

5 Whereas, Our understanding of the health care needs of children within the foster care system
6 has increased through evidence-based research; therefore be it
7

8 RESOLVED, That our American Medical Association amend policy H-60.910, *Addressing*
9 *Healthcare Needs of Children in Foster Care*, by addition and deletion to read as follows:
10

11 **Addressing Healthcare Needs of Children in Foster Care H-60.910**

12 Our AMA advocates for comprehensive, ~~and evidence-based, trauma-informed~~ care that
13 addresses the specific mental, developmental, and physical health care needs of children in
14 foster care. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Citation: Res. 907, I-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-23)

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: Prescribing Guided Physical Activity for Depression and Anxiety

Referred to: Reference Committee D

1 Whereas, Depression and anxiety are medical conditions with neurophysiological basis¹; and
2

3 Whereas, Depression and anxiety cause accelerated aging and put patients at risk for further
4 chronic medical conditions²; and
5

6 Whereas, People with mental health conditions have lower life expectancy than the general
7 population of 12–15 years, are at higher risk of developing chronic illnesses such as diabetes
8 and heart disease, both of which are impacted by exercise^{6,7}; and
9

10 Whereas, Traditionally physical therapy is only recommended or covered by insurances for
11 traditionally “medical” diagnoses, not for diagnoses such as depression and anxiety which also
12 have a physical and medical component; and
13

14 Whereas, Due to increasing polypharmacy and patients experiencing side effects from
15 psychotropic medications⁵ nonpharmacologic approaches to management of depression and
16 anxiety should be studied and promoted; and
17

18 Whereas, A meta-analysis of 33 RCT showed that resistance exercise training significantly
19 reduced depressive symptoms³; and
20

21 Whereas, Recent meta-analysis on structured exercise programs conclude that exercise has a
22 moderate to large antidepressant effect^{8,9}; and
23

24 Whereas, A meta-analysis of six prospective studies involving 26,473 participants and found a
25 significantly decreased risk of depression symptoms among participants with strong handgrip
26 strength (RR=0.74)⁴; and
27

28 Whereas, Preventative health measures can not only help alleviate suffering and improve
29 quality of life for our patients, they can also cost the healthcare system less money in the long
30 run¹⁰; therefore be it
31

32 RESOLVED, That our American Medical Association study evidence of the efficacy of physical
33 activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral
34 activation and outcomes on depressive symptoms. (Directive to Take Action)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928

1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Citation: Res. 515, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-23)

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: National Emergency for Children

Referred to: Reference Committee D

- 1 Whereas, During March–October 2020, the proportion of mental health-related visits in
2 emergency departments increased by 24% among U.S. children aged 5–11 years and 31%
3 among adolescents aged 12–17 years, compared with 2019; and
4
5 Whereas, Visits for overall mental health conditions among all children and adolescents
6 accounted for a larger proportion of all pediatric visits during 2020, 2021, and January 2022
7 than during 2019, with variation by age group and mental health condition; and
8
9 Whereas, Suicide is the second leading cause of death for youth ages 10-18 in the United
10 States; and
11
12 Whereas, Suicide rates for American Indian or Alaska Native, Asian, Black, Hispanic, and
13 multiracial youth increased dramatically between 2018 and 2021 with the highest rate of
14 increase among non-Hispanic Black youth at 36.6%; and
15
16 Whereas, 20.1% of youth ages 12-17 had a major depressive episode in the past years,
17 compared to 15.7% of youth in 2019; and
18
19 Whereas, In 2021, 42% of high school students reported feeling persistently sad or hopeless
20 and 29% reported experiencing poor mental health; and
21
22 Whereas, Nearly half of all youth with mental health disorders do not receive treatment; and
23
24 Whereas, The American Academy of Child and Adolescent Psychiatry, the American Academy
25 of Pediatrics, and the Children’s Hospital Association declared a National State of Emergency in
26 Children’s Mental Health in 2021; therefore be it
27
28 RESOLVED, That our American Medical Association declare a national state of emergency in
29 children’s mental health. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire;
Rhode Island; Vermont

Subject: Reducing Sodium Intake to Improve Public Health

Referred to: Reference Committee D

1 Whereas, Sodium is an essential nutrient necessary for maintenance of health and whole-body
2 function and excess sodium is linked to adverse health outcomes, including increased blood
3 pressure. The primary contributors to dietary sodium consumption depend on the cultural
4 context and dietary habits of a population. Nine out of 10 U.S. men and women will develop
5 hypertension at some point in their lives¹; and
6

7 Whereas, The main source of sodium in our diet is salt, sodium can be found naturally in foods
8 such as milk, meat, and shellfish as well as in common condiments, such as soy sauce and
9 sodium glutamate. Sodium is often found in high amounts in processed foods. These foods are
10 often more affordable and available to the general public resulting in higher consumption of
11 sodium; and
12

13 Whereas, On average people consume 9-12 grams of salt per day, or around twice the
14 recommended maximum level of intake. Salt intake of less than 5 grams per day for adults
15 helps to reduce blood pressure and risk of cardiovascular disease, stroke, and coronary heart
16 attack. The principal benefit of lowering salt intake is a corresponding reduction in high blood
17 pressure. Researchers estimate that reducing the average daily sodium intake in the U.S. to
18 2,300 milligrams (about 1 teaspoon of salt) per day would prevent 11 million cases of
19 hypertension and would save \$18 billion in health care costs each year³. An estimated 2.5
20 million deaths could be prevented each year if global salt consumption were reduced to the
21 recommended level; and
22

23 Whereas, World Health Organization (WHO) Member States have agreed to reduce the global
24 population's intake of salt by a relative 30% by 2025. Reducing salt intake has been identified
25 as one of the most cost-effective measures countries can take to improve population health
26 outcomes. Key salt reduction measures will generate an extra year of healthy life for a cost that
27 falls below the average annual income or gross domestic product per person; and
28

29 Whereas, The U.S. Food & Drug Administration (FDA) released new voluntary guidance on
30 October 13, 2021, encouraging the food industry to gradually reduce sodium in commercially
31 processed, packaged, and prepared foods over the next two and a half years—with the aim of
32 helping Americans reduce their average levels of sodium from 3,400 to 3,000 mg/day; and
33

34 Whereas, In 2013, the World Health Assembly (WHA) agreed to global voluntary prevention
35 targets including a relative reduction in the intake of salt by 2025. The "Global Action Plan for
36 the Prevention and Control of Noncommunicable Diseases 2013-2020" gives guidance and a
37 menu of policy options for Member States, WHO and other UN agencies to achieve the targets;
38 and

1 Whereas, Some manufacturers have voluntarily agreed to cut back on sodium as part of New
2 York City's National Salt Reduction Initiative⁶. The aim of this initiative is to guide a voluntary
3 reduction of salt levels in packaged and restaurant foods, with the primary goal of cutting the
4 salt in packaged and restaurant foods by 25% over five years – which would reduce the nation's
5 salt intake by 20% and prevent thousands of deaths; and
6

7 Whereas, Finland and the United Kingdom have led successful sodium reduction efforts. In
8 Finland, a government-led program of education, salt-labeling legislation, and pressure on the
9 food industry has led to a 30 percent reduction in salt intake, from 12,000 milligrams a day to
10 around 9,000 milligrams today⁷; therefore be it
11

12 RESOLVED, That our American Medical Association work with all relevant stakeholders to
13 advocate and advise salt reduction through public outreach that may include, but not be limited
14 to, policy changes, ad campaigns, educational programs, including those starting in schools,
15 and food labeling (Directive to Take Action); and be it further
16

17 RESOLVED, That our AMA study and report back at the 2024 Annual Meeting the effectiveness
18 and feasibility of salt reduction strategies with specific interventions such as:
19

- 20 1. Consumer awareness and empowerment of populations through social marketing and
21 mobilization to raise awareness of salt alternatives and the need to reduce salt intake
- 22 2. Government policies, including appropriate fiscal policies and regulation, to ensure food
23 manufacturers produce healthier affordable low-sodium foods and retailers make such
24 products available
- 25 3. Integrating salt reduction strategies and alternatives into the training curriculum of food
26 handlers
- 27 4. Removing opportunistic use of saltshakers
- 28 5. Introducing and regulating "High in Sodium" (or similar) front-of-pack product labels or
29 prominent shelf labels
- 30 6. Automating targeted sodium dietary advice to people visiting health facilities
- 31 7. Advocating for people to limit their intake of products high in salt and advocating that
32 they reduce the amount of salt used for cooking
- 33 8. Educating and providing a supportive environment for children to encourage early
34 adoption of low salt diets
- 35 9. Reducing salt in food served by restaurants and catering outlets, and labelling the
36 sodium content of this food. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

Referred to: Reference Committee D

1 Whereas, Our American Medical Association has established policy H-420.979, *AMA Statement*
2 *on Family and Medical Leave*, regarding employment leave with reasonable job security and
3 health benefit security; and
4

5 Whereas, Our AMA policy H-420.979 also includes leave for adoption or for foster child
6 placement leading to adoption; and
7

8 Whereas, There are over 600,000 children in 2021 who were in the foster care system in our
9 country; and
10

11 Whereas, Current research indicates that children who are removed from their homes and enter
12 the foster care system have better outcomes if they are placed in a home environment as
13 opposed to a residential setting; and
14

15 Whereas, There is a current shortage of adults who serve as foster parents for children in the
16 foster care system; and
17

18 Whereas, Incorporating a new child into a foster home is a critical time in both the child's and
19 foster parent's lives in order to develop a successful placement for both; and
20

21 Whereas, Protected leave from work as needed for foster placement, not necessarily leading to
22 adoption only, would provide for improved successful placement; therefore be it
23

24 RESOLVED, That our American Medical Association amend H-420.979, *AMA Statement on*
25 *Family and Medical Leave*, by addition and deletion to read as follows:
26

27 **AMA Statement on Family and Medical Leave H-420.979**

28 Our AMA supports policies that provide employees with reasonable job security and continued
29 availability of health plan benefits in the event leave by an employee becomes necessary due to
30 documented medical conditions. Such policies should provide for reasonable periods of paid or
31 unpaid:
32

- 33 1) Medical leave for the employee, including pregnancy, abortion, and stillbirth;
- 34 2) Maternity leave for the employee-mother;
- 35 3) Leave if medically appropriate to care for a member of the employee's immediate family,
36 i.e., a spouse or children; and
- 37 4) Leave for adoption or for foster placement of a child in foster care in the home leading to
38 adoption. Such periods of leave may differ with respect to each of the foregoing
39 classifications and may vary with reasonable categories of employers. Such policies

1 should encourage voluntary programs by employers and may provide for appropriate
2 legislation (with or without financial assistance from government). Any legislative
3 proposals will be reviewed through the Association's normal legislative process for
4 appropriateness, taking into consideration all elements therein, including
5 classifications of employees and employers, reasons for the leave, periods of leave
6 recognized (whether paid or unpaid), obligations on return from leave, and other
7 factors involved in order to achieve reasonable objectives recognizing the legitimate
8 needs of employees and employers. (Modify Current HOD Policy)

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

Received: 5/2/23

RELEVANT AMA POLICY

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22;

Reference Committee E

CSAPH Report(s)

- 01 Oppose Scheduling of Gabapentin
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
- 03 Regulation and Control of Self-Service Labs

Resolution(s)

- 501 AMA Study of Chemical Castration in Incarceration
- 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
- 503 Increasing Diversity in Stem Cell Biobanks and Disease Models
- 504 Regulating Misleading AI Generated Advice to Patients
- 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
- 506 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 507 Recognizing the Burden of Rare Disease
- 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
- 509 Addressing Medical Misinformation Online
- 510 Comparative Effectiveness Research
- 511 Regulation of Phthalates in Adult Personal Sexual Products
- 512 Wheelchairs on Airplanes
- 513 Substance Use History is Medical History
- 514 Adolescent Hallucinogen-Assisted Therapy Policy
- 515 Regulate Kratom and Ban Over-The-Counter Sales
- 516 Fasting is Not Required for Lipid Analysis

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 01-A-23

Subject: Oppose Scheduling of Gabapentin

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee E

1 American Medical Association (AMA) Policy D-120.927, “Oppose Scheduling of Gabapentin,”
2 calls for the study of off-label use and potential risks and benefits of gabapentin to the general
3 population as well as to those individuals with substance use disorders. This report investigates the
4 evidence base for off-label prescribing of gabapentin, the regulatory landscape of gabapentin for
5 maximizing patient access and minimizing stigma, and adverse events during the ongoing overdose
6 crisis.

7
8 BACKGROUND

9
10 In February 2022, the U.S. Food and Drug Administration (FDA) received a petition from a
11 consumer advocacy group requesting that gabapentin and gabapentin enacarbil be designated as
12 schedule V under the Controlled Substances Act of 1970. In June 2022, Resolution 514-A-22 (now
13 policy D-120.927) was adopted by the House of Delegates which called upon the AMA to oppose
14 this petition and any other efforts to schedule gabapentin and its salts pending review of the risk
15 and benefits of gabapentin use in the general public and those with substance use disorders.

16
17 METHODS

18
19 English language articles were selected from searches of PubMed, Cochrane Library and Google
20 Scholar using the search terms “gabapentin OR neurontin”, “gabapentin AND off-label”,
21 “gabapentin AND controlled substance”, “gabapentin AND substance use disorder” and
22 “gabapentin AND opioids”. Additional articles were identified by manual review of the reference
23 lists of pertinent publications. Web sites managed by government agencies and applicable
24 organizations were also reviewed for relevant information.

25
26 DISCUSSION

27
28 *History of Gabapentin*

29
30 Gabapentin, a gabapentinoid originally marketed under the trade name Neurontin by Parke-Davis,
31 is an analog of the neurotransmitter gamma-aminobutyric acid. While the exact mechanism of
32 action for gabapentin is not known, it is generally accepted that it binds to the $\alpha 2\delta$ subunit of
33 calcium-activated ion channels.¹ It is hypothesized that this then further modulates neurotransmitter
34 release, which may affect the dopaminergic pathways associated with reward-seeking behavior and
35 substance use disorders.

36
37 Neurontin (gabapentin) was initially approved by the FDA in 1993 for adjunctive therapy of partial
38 onset seizures in patients aged 12 or older.² In 2000, that indication was expanded by the FDA for

1 pediatric patients over the age of three. In 2002, a second indication for post-herpetic neuralgia was
2 approved by the FDA. It is currently available as a generic medication. Despite the relatively
3 narrow scope of approved indications, Neurontin (gabapentin) was marketed by its manufacturer,
4 Parke-Davis, for a variety of off-label indications such as neuropathic pain, epilepsy monotherapy,
5 bipolar disorder, migraine, and attention-deficit disorder, due to data which showed improved
6 outcomes in these disease states.³ It was estimated that prior to generic competition becoming
7 available in 2004, Neurontin (gabapentin) products were grossing over \$3 billion a year in sales.

8
9 To maximize market penetration, Parke-Davis was accused of pursuing illegal strategies like the
10 ethically dubious *quid pro quo* solicitation of ghost-written, pro-Neurontin editorials.⁴ As a result,
11 Parke-Davis's parent organization Warner-Lambert (and ultimately Pfizer, after it acquired the
12 company in 2000) pleaded guilty to two counts of violating the Food, Drug & Cosmetics Act and
13 was required to pay \$430 million in both civil and criminal damages.⁵ A separate lawsuit for these
14 marketing practices from Blue Cross Blue Shield of Louisiana, was settled for \$325 million, and a
15 third lawsuit regarding anti-trust activity to prevent generic gabapentin off the market, was settled
16 in 2014 for \$190 million.⁶ Pfizer did not admit wrongdoing in the latter two settlements.

17
18 It is critical to understand the history of Neurontin advertising when assessing the perception of
19 off-label prescribing of gabapentin. A portion of off-label gabapentin prescriptions could be due to
20 misleading marketing information. However, it should be noted that these were unethical and
21 illegal *business* practices, and should be viewed separately from issues of safety, efficacy, or
22 overall utility in patient care.

23
24 Gabapentin and its salts are FDA-approved to treat postherpetic neuralgia and adjunctive treatment
25 of epilepsy with partial onset seizures, yet one study found that up to 95 percent of gabapentin
26 prescriptions were for off-label uses such as fibromyalgia, bipolar affective disorder, and alcohol
27 use disorder.⁷ Another study found that amongst 160 commonly prescribed drugs, gabapentin had
28 the highest off-label prescription rate, and that 80 percent of the time, its off-label usage had little-
29 to-no scientific support.⁸ As of a 2020 survey, seven states have made gabapentin a schedule V
30 controlled substance, and 13 states have added it to their prescription drug monitoring programs
31 (PDMP). At least three other states have considered scheduling or otherwise monitoring
32 prescriptions of gabapentin.

33 34 *Evidence for Off-Label Uses of Gabapentin*

35
36 A title search for the term "gabapentin" of Cochrane Library reveals seven systematic reviews or
37 meta-analyses of gabapentin uses, and over 1,700 individual trials. Gabapentin is currently only
38 FDA approved for postherpetic neuralgia and adjunctive therapy in epilepsy, but trials have been
39 conducted to evaluate gabapentin for a plethora of other indications. To give a sense of the sheer
40 breadth of applications for which gabapentin has been investigated, a sample of the 1700 trials
41 include, but are not limited to: diabetic neuropathy, restless leg syndrome (RLS), sleep, smoking
42 cessation, alcohol use disorder, cocaine use disorder, cannabis use disorder, fibromyalgia, tinnitus,
43 social phobia, carpal tunnel syndrome, post-surgery pain, uremic pruritis, radicular pain, migraine,
44 bipolar disorder, delirium, surgery pretreatment, topical anti-itching, post-operative nausea,
45 phantom limb pain, acute mania, hot flashes and postural tachycardia syndrome.

46
47 Due to the volume of studied off-label uses of gabapentin and the varying range of study quality, it
48 is impossible to synthesize the evidence base for each indication. Table One, presented below,
49 attempts to capture some of the most common off-label uses of gabapentin and the current
50 understanding of the evidence for its use.

1 The current evidence shows that gabapentin may have some useful off-label applications primarily
2 in the fields of pain management and mental health, such as diabetic neuropathy⁹, post-operative
3 pain¹⁰, and conditional anxiety.¹¹ For some applications, such as fibromyalgia¹² or migraine
4 prophylaxis¹³, the current evidence base is less compelling. This report should not be construed as
5 clinical instructions or an endorsement of the off-label usage of gabapentin. Prescribers should
6 utilize evidence-based decision-making when prescribing any medication for off-label uses.

7 8 *Gabapentin and the Ongoing Overdose Epidemic* 9

10 Proponents of scheduling gabapentin raise concerns over potential misuse, morbidity, and mortality
11 associated with gabapentin.¹⁴ Overdoses solely attributed to gabapentin are described in the
12 literature as “rare”.¹⁵ However, approximately 9.7 percent of overdose deaths examined in the
13 United States between 2019-2020 detected gabapentin.¹⁶ Of those overdose deaths, almost 90
14 percent had at least one opioid (prescription or illicit) present in conjunction with gabapentin.
15 Similar results were observed in a study of fatalities associated with gabapentin in England – of
16 913 deaths in which gabapentin was detected, opioids were co-detected in 91 percent.¹⁷ In 25
17 percent of cases in which gabapentin and an opioid (including methadone and buprenorphine) were
18 present, the two medications were co-prescribed. Finally, they found that only one of 913 deaths
19 could be attributed solely to gabapentin toxicity. Gabapentin is recognized as a ‘cutting’ agent for
20 heroin.¹⁸ As such, gabapentin’s role appears to potentiate additional respiratory depression when
21 used concomitantly with other drugs known to cause respiratory depression, such as opioids. In a
22 2019 warning from the FDA, they indicated that “[t]here is less evidence supporting the risk of
23 serious breathing difficulties in healthy individuals taking gabapentinoids alone.”¹⁹

24
25 Gabapentin monotherapy misuse is less documented. Individuals may use high doses of gabapentin
26 to induce euphoria but many, if not all, of these cases are observed in individuals with a history of
27 substance use disorders.²⁰ In Germany (a country with a significantly lower overdose mortality rate
28 than the United States), a survey of addiction medicine specialists placed gabapentin in a similar
29 risk category as medications without misuse risk, such as non-steroidal anti-inflammatory drugs.²¹

30
31 It is difficult to assess the extent of gabapentin misuse. Online marketing surveys from the United
32 Kingdom estimate that gabapentin misuse across the general population is as high as 1 percent.²²
33 However, this number does not appear to be corroborated by clinical data, which found that there
34 were only 576 reported cases of gabapentin misuse to the FDA’s Adverse Events Reporting System
35 across a 5-year period during which there were approximately 200 million prescriptions of
36 gabapentin filled in the United States.²³

37
38 Rather, gabapentin misuse is often reported in the context of potentiating other substances, such as
39 individuals under routine drug screens who potentiate buprenorphine and/or naloxone with
40 gabapentin to induce euphoria while testing negative for opioids. Approximately 9 percent of
41 individuals seeking treatment for opioid use disorders self-reported misuse of gabapentin upon
42 entry into opioid use treatment clinics in the United States from 2019-2020.²⁴ Systematic reviews
43 have found that the largest risk factor for gabapentin misuse is an opioid use disorder.²⁵

44
45 The growing rates of use of gabapentin and subsequent perception of its misuse are tied to the
46 ongoing drug-related overdose epidemic. Based on the Centers for Disease Control and Prevention
47 Clinical Practice Guidelines for Prescribing Opioids for Pain, utilization of multimodal pain
48 management approaches is critical to supporting effective care²⁶. As such, gabapentin has seen
49 increases in prescribing as a key component of this multimodal approach, particularly in patients
50 who have comorbidities that limit the use of other pain management medications.²⁷ In parallel to

1 concerns with increased opioid use, despite clear evidence for improved outcomes, stigmatizing
2 language of diversion and criminal activity is emerging surrounding gabapentinoid products.
3 The AMA has significant policy, advocacy, and ongoing work supporting evidence-based decision
4 making regarding the proper care of patients with pain and/or opioid use disorders. Research has
5 shown repeatedly that the best outcomes are those which are patient-centric, recognizing that
6 opioid use disorder is a medical diagnosis requiring treatment, not a criminal issue requiring
7 incarceration.^{28,29}

8 9 REGULATING GABAPENTIN

10
11 Only a small number of states have chosen to pursue statutory or regulatory strategies specific to
12 gabapentin. This includes classifying the medication as a schedule V controlled substance and
13 requiring use of the PDMP; or requiring use of the PDMP without scheduling gabapentin. The
14 Drug Enforcement Administration (DEA), with authority from the Controlled Substances Act,
15 maintains a list of substances which are placed under increased regulatory scrutiny, including
16 registration, production quotas, restrictions on research, and criminal or civil penalties for
17 possession.³⁰ Substances are placed in different categories, or schedules, based on three factors:
18 potential for misuse, whether there are accepted medical uses, and the potential for addiction.
19 Schedule V is the lowest risk category, and are generally used for antidiarrheal, antitussive, and
20 analgesic medications. Examples of schedule V drugs include Lomotil, Motofen, Parepectolin, and
21 Lyrica (a gabapentinoid).

22
23 When the original resolution regarding gabapentin scheduling was presented at the House of
24 Delegates at the 2022 Annual Meeting, testimony provided anecdotal evidence towards concerning
25 patterns of misuse in non-prescribed gabapentin usage, particularly in incarcerated populations.
26 Since potential for misuse is a key criterion for DEA scheduling, it is important to appreciate the
27 magnitude of misuse. However, published literature on misuse of gabapentin is limited, and
28 primarily in populations co-using with opioids. For example, in one study of individuals seeking
29 inpatient opioid detoxification, 71 percent of respondents indicated that they were using gabapentin
30 without a prescription for the purpose of reducing opioid withdrawal symptoms, and 58 percent
31 reported they used gabapentin without a prescription to reduce their cravings for opioids.³¹ At the
32 population-level, one study of law enforcement found 407 cases of diverted gabapentin between
33 the years of 2002 to 2015, with a peak rate of 0.027 cases per 100,000 population.³² Another study
34 found that 3 percent of commercially insured patients requested 3 or more prescription claims
35 above the established dosage thresholds if they were seeking gabapentin on its own.³³ This number
36 rose to 24 percent if they were seeking gabapentin co-prescribed with opioids. Due to the
37 interconnectivity of gabapentin misuse with opioid use disorders – including instances which are
38 intended to reduce opioid use – it is difficult to assess the true misuse risk of gabapentin.

39
40 Currently, gabapentin is not scheduled as a controlled substance by the DEA, but seven states
41 (Alabama, Kentucky, Michigan, North Dakota, Tennessee, Virginia and West Virginia) have
42 classified gabapentin as a schedule V controlled substance.³ While schedule V is the lowest risk
43 categorization of the Controlled Substances Act of 1970 (although states may have different
44 definitions under their own controlled substance regulations), it still requires physicians and other
45 health care professionals who prescribe or dispense controlled substances to register with the DEA.
46 Schedule V controlled substances are subject to restrictions on storage, security, and the amount,
47 timing and frequency of refills.³⁴ A sub-population of patients particularly sensitive to changes in
48 regulations are those within the carceral system, where prescribing of gabapentin is already heavily
49 scrutinized, and the stigma and criminalization of pain treatment is highest.³⁵

1 There are 13 states, including Connecticut, Indiana, Louisiana, Ohio, Oregon, and Utah, that have
2 required reporting of gabapentin prescriptions into their PDMPs. These requirements are meant, in
3 part, to allow physicians, pharmacists and other health care professionals to view recent
4 prescriptions and prescription patterns of gabapentin and other controlled substances, such as
5 opioids and benzodiazepines, to support evidence-based prescribing decisions. The AMA and
6 many others have long supported using PDMPs as part of the clinical decision-making process, but
7 emphasized that information in a PDMP is only one of many factors a physician should consider
8 when determining whether to prescribe controlled substances³⁶.

9
10 With respect to the question whether to add gabapentin as a Schedule V Controlled Substance, the
11 role of the PDMP needs additional consideration. When PDMP requirements first came into vogue,
12 the general argument for mandating their use was the potential to reduce opioid-related misuse and
13 opioid-related mortality. There is some evidence showing use of PDMPs increased the ability of
14 physicians and pharmacists to identify multiple prescriber events, that is, when an individual
15 received three or more opioid prescriptions from three or more different prescribers or dispensers
16 within a short time frame, typically 30 days.³⁷ Many states have reported reductions in these
17 multiple prescription events, but as detailed in AMA Board of Trustees Report 3-I-16, merely
18 identifying a multiple prescriber event is not sufficient to know whether a patient is engaging in
19 aberrant behavior, someone who has uncoordinated care, or is pursuing illegal prescriptions. Thus,
20 while reductions in multiple prescriber events are likely positive, it is not clear whether the
21 reductions have led to improved patient outcomes. In addition, there has been no reduction in
22 opioid-related mortality as PDMP use has increased. In 2022, physicians and other health care
23 professionals used PDMPs more than 1.1 billion times while the overdose epidemic grew to more
24 than 107,000 fatalities.³⁸ Furthermore, there is no compelling evidence suggesting that PDMPs
25 helped improve outcomes for patients with pain. There also continues to be confusion about how to
26 optimize PDMPs in clinical practice.³⁹

27
28 It is important to note that PDMPs have limitations. While different PDMP platforms claim to
29 allow for interstate access of patient information, such retrieval is not always reliable if the user has
30 not set the PDMP up to view all states—or even all neighboring states. There also continue to be
31 challenges in reporting intervals from when a prescription is dispensed to when data is uploaded to
32 the PDMP. Physicians and other health care professionals also continue to report frustration with
33 PDMP-induced disruptions or poor interoperability with electronic health records.^{40,41} Given the
34 absence of data suggesting that a PDMP reduces drug-related misuse or other harms, along with a
35 clear-eyed view of PDMP limitations, it is unlikely that having gabapentin in the PDMP—by virtue
36 of it being a Schedule V Controlled Substance—will improve outcomes, increase meaningfully
37 available information, or improve patient outcomes.

38
39 In comparing states which designated gabapentin as a schedule V controlled substance and states
40 which required gabapentin reporting to the PDMP alone, states that designated gabapentin a
41 controlled substance (which includes automatic registration in the state PDMP), saw a significant
42 decrease in the number of gabapentin prescriptions.⁴² By contrast, states which implemented a
43 PDMP reporting-only approach saw little change in the number of gabapentin prescriptions.⁴³ This
44 is not surprising as the requirements for prescribing a Schedule V controlled substance are greater
45 than for a non-controlled substance.

46
47 Proponents of scheduling gabapentin as a controlled substance use this evidence, that designating
48 gabapentin as a schedule V controlled substance reduces prescriptions, as a surrogate for
49 decreasing patient harm.⁴⁴ The literature regarding scheduling gabapentin as a controlled substance
50 lacks information regarding indication for use or patient oriented outcomes, such as pain control,
51 increased functioning, prevalence of adverse events or evidence of decreases in misuse. Stigma and

1 prescribing barriers have the potential to impede access to care, particularly pain management.
2 When strategies simply aim to decrease the overall number of prescriptions, marginalized and/or
3 underserved patients will often be turned away first. Black patients are at highest risk for receiving
4 inadequate pain treatment and are up to 36 percent less likely to receive *any* analgesic
5 pharmacotherapy compared to white patients.^{45,46} In the event that they do present with a substance
6 use disorder, Black patients covered by Medicaid have a 50 percent lower rate of prescribing
7 buprenorphine compared to white patients when controlled against other clinical and demographic
8 factors.⁴⁷ There are many reasons for this inequity, but at its core, the implicit bias and associations
9 made between Black patients, pain medication, and criminal behavior is difficult to ignore.⁴⁸ It is
10 likely that further stigmatization of gabapentin prescribing and emphasis on misuse and diversion
11 could result in similar inequities.

12
13 In addition, the nation's overdose epidemic and its intense focus on reducing opioid prescriptions
14 provide a useful point of comparison. In 2012-2013, physicians began to reduce opioid
15 prescriptions in response to growing concerns about misuse. Between 2012-2021, opioid
16 prescriptions have declined in every state—46.4 percent nationwide.⁴⁹ As noted above, this
17 reduction has not led to reduced drug-related overdose or death. The inverse actually has occurred.
18 This is not to say that reduction in opioid prescribing were not warranted in certain circumstances,
19 but as noted by the AMA in comments to the CDC and others, the focus should always have been
20 on ensuring patients with pain received the right care at the right time, which may include opioid
21 therapy⁵⁰. The AMA supports continued efforts to enhance medical education and training,
22 including those focused on medications that may be misused or used without a prescription. The
23 AMA further supports efforts, including research and medical society collaboration to support
24 effective pain care. These efforts could be interpreted to include gabapentin, but are certainly not
25 limited to one medication and its potential uses, as noted above. These efforts already occur
26 without having to increase the barriers to gabapentin by making it a Schedule V controlled
27 substance. An end goal of simply reducing prescriptions is shortsighted and inappropriate.

28
29 Beyond regulatory solutions, best practices for prescribing gabapentin continue to evolve. The
30 FDA is the appropriate agency to continue to evaluate drug safety. The AMA and organized
31 medicine are the appropriate entities to support and encourage enhanced education about
32 prescribing practices, including gabapentin.⁵¹

33 34 CONCLUSION

35
36 With the longevity of gabapentin on the market, combined with the incredibly wide range of trials,
37 and the low incidence of adverse events, there is not a compelling reason to designate gabapentin
38 as a controlled substance. The available evidence does not demonstrate that the benefits of
39 scheduling gabapentin outweigh the risk of patient harm. Instead, strategies to increase prescriber
40 awareness of gabapentin's potentiator effect and more thoughtful prescribing, particularly in
41 groups at high-risk for overdose, will target increases in medication safety. The recognition of
42 stigma and bias is critical for continued evidence-based decision-making and increased access to
43 those in need.

44 45 RECOMMENDATIONS

46
47 The Council on Science and Public Health recommends that the following be adopted and the
48 remainder of the report be filed.

1 1. That Policy D-120.927, “Oppose Scheduling of Gabapentin” be amended by addition and
2 deletion to read as follows with recognition that several aspects of this directive have been
3 accomplished:

4
5 Our AMA will:

- 6 1. actively oppose the placement of (a) gabapentin (2-[1-(aminomethyl)cyclohexyl]acetic
7 acid), including its salts, and all products containing gabapentin (including the brand name
8 products ~~Gralise and Neurontin~~) and (b) gabapentin enacarbil (1-[[[(1R)-1-[(2-
9 methylpropanoyl)oxy]ethoxy]carbonyl]amino]methyl]cyclohexyl)acetic acid), including
10 its salts, (~~including the brand name product Horizant~~) into schedule V or other restricted
11 class of the Controlled Substances Act;
- 12
13 ~~2. submit a timely letter to the Commissioner of Food and Drug for the proceedings assigned~~
14 ~~docket number FDA-2022-P-0149 in opposition to placement of gabapentin and~~
15 ~~gabapentin enacarbil into the schedule V of the Controlled Substance Act; and~~
16
17 ~~3. study the off label use and potential risks and benefits of gabapentin to the general~~
18 ~~population as well as to those individuals with substance use disorders.~~
- 19
20 2. affirm that given currently available data, the FDA and DEA have used the appropriate
21 process for evaluating the safety, efficacy, and risk of misuse and dependency for
22 gabapentin and its salts;
23
24 3. support the promotion of gabapentin-related research and education, particularly the risk of
25 gabapentinoids when taken concomitantly with opioids, including in current clinical
26 practice and undergraduate, graduate and post-graduate education. (Modify Current AMA
27 Policy)
28

29 2. That our AMA reaffirm Policies H-120.988, “Patient Access to Treatments Prescribed by Their
30 Physicians”, H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to Address
31 Pain”, and H-95.922, “Substance Use and Substance Use Disorders.” (Reaffirm Current AMA
32 Policy)

Fiscal Note: less than \$1,000

TABLE 1: SELECT STUDIES EVALUATING OFF-LABEL GABAPENTIN USES

Indication	# of Participants	Total Daily Dose Range (mg)	Clinical Measures Evaluated^a	Favors Gabapentin Usage Over Risk of Use?	Reference
Diabetic neuropathy	5914	>1200	Substantial (>50%) or moderate (>30%) reduction in pain	Yes	9
Postoperative pain	370	250-500	Summed pain intensity difference	Yes	10
Conditional anxiety	934	300-1200	State-Trait Anxiety Inventory	Yes	11
Bipolar disorder	282	600-4800	Young Mania Rating Scale	No	11
Panic disorder	103	600-3600	Panic and Agoraphobia Scale	No	11
Depression	28	300-1800	Clinical Global Impressions-Severity Scale	Yes	11
Fibromyalgia	150	2400	50% reduction in pain	No	12
Migraine prophylaxis	1009	900-2400	Headache frequency	No	13
Sleep	4684	600-3600	Pittsburgh sleep quality index score	Yes	52
Cocaine use disorder	235	1600-2400	Report or evidence of use	No	53
Alcohol use disorder	269	600-1500	Report of heavy alcohol use	Yes	54
Hot flashes	600	1800	Frequency and severity of hot flashes	Yes	55
Restless leg syndrome	87	200	RLS rating scale and sleep quality	Yes	56
Chronic pelvic pain (women)	60	300-2700	Difference in pain score (vs. placebo)	Yes	57
Carpal tunnel syndrome	140	900	Global symptom score	No	58

^a – Some clinical measures used in studies were excluded from summary for brevity.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 02-A-23

Subject: Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee E

Resolution 523-A-22, “Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices” was referred by the House of Delegates (HOD). This report serves as the Council on Science and Public Health’s (CSAPH) findings and recommendations regarding medical device regulation.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “medical device AND 510(k)” and “medical device AND post-market surveillance”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

In the context of regulatory oversight by the Food and Drug Administration (FDA), a medical device has a broad definition. According to the Food, Drug and Cosmetic Act:

a device is: an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: [...]

(B) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

(C) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

As such, the breadth of items captured within this regulatory framework is expansive, ranging from tongue depressors and eyeglasses to x-ray machines and hip replacements. In addition to physical objects used as medical devices, software and algorithms are also captured within this definition. As such, the FDA classifies software into two broad categories: software *in* a medical device and software *as* a medical device (SaMD). CSAPH recognizes that software, particularly SaMD, is rapidly becoming a large part of medical care and may warrant further examination beyond the

findings and recommendations of this report, which are intended to be generalizable to all medical devices.

DISCUSSION

The 510(k) Regulatory Pathway

When applying for a new medical device, the device is first evaluated for risk category: I (lowest risk), II (medium risk) or III (highest risk). Risk category is determined by a variety of factors, such as by comparing the device to a similar, known, device. If a device is found to be like a device already approved by the FDA, it may be classified as low (class I) or medium (class II) risk. Examples of devices commonly found to be class I include electric toothbrushes, tongue depressors, bandages, hospital beds, and non-electric wheelchairs. Examples of devices commonly found to be class II include catheters, pregnancy test kits, syringes, contact lenses, and surgical gloves. Examples of devices commonly found to be class III include breast implants, pacemakers, defibrillators, and cochlear implants. Approximately 1% of all new medical device applications from 2003 to 2017 were evaluated as high risk (class III).^{i,ii}

If a medical device is found to be class I they are typically exempt from normal testing. If deemed a class II risk, manufacturers may submit a 510(k) application as pre-market notification (PMN) to the FDA. Class II risk devices are subjected to an equivalence evaluation comparing this product to one currently on the market through these 510(k) processes. 510(k) applications are processed within 90 days and once approved, the device is eligible for market. By contrast, class III devices must undergo pre-market approval (PMA) which requires two large clinical trials. According to a 2010 industry survey, pursuing pre-market approval in the United States takes on average 54 months to complete compared to 11 months in European countries.ⁱⁱⁱ

Medical device market approval differs from drug approval in a few critical ways, which may help illustrate why the 510(k) pathway is so desirable for medical device manufacturers. Table 1 in the appendix of this report highlights some of these differences. Clinical trial design for medical devices can be extremely difficult, and in some cases unethical. For example, a placebo control for a medical device could require a high-risk sham surgery. As such, subjecting all new medical devices to undergo clinical trials may substantially hinder innovation, particularly from physicians seeking small tweaks or customizations to products they use routinely.

But on the other hand, if a medical device does cause harm to a patient, one cannot simply discontinue having an implanted device without significant intervention unlike if they were experiencing adverse events to a new medication that could be quickly stopped. As such, the 510(k) pathway has been subject to intense public scrutiny, both in the media and by elected officials.^{iv} Many recalls of medical devices are voluntarily initiated by the manufacturer due to liability concerns or public perception decreasing sales rather than by official FDA action.

The FDA has recently begun piloting a new program within the 510(k) framework, called the Safety and Performance Based Pathway. This pathway provides an alternative to the current equivalence evaluation for a small subset of devices that are highly studied and well-known. In the Safety and Performance Based Pathway, the FDA sets forth explicit benchmarks that medical devices must satisfy to demonstrate safety and efficacy to gain 510(k) approval.^v For example, if a resorbable surgical sutures manufacturer wished to market a new design, the FDA has guidance for the appropriate diameter, needle attachment, tensile strength, sterilization, shelf life and resorption profile for new suture designs to meet to receive 510(k) classification.^{vi} This pathway provides

added safety and efficacy requirements to this moderate risk class. However, participation in the Safety and Performance Based Pathway is currently optional.

Device Equivalence

To be eligible for the 510(k) approval, a manufacturer must first establish that their device is “substantially equivalent” to a previously known, FDA-approved predicate device.^{vii} For the purposes of regulatory approval, the FDA considers both safety and functionality when determining equivalence. First, they investigate whether the device is to be used for the same primary purpose, and they then evaluate whether the device is expected to have a similar safety profile. For example, if a device were to change its power source (such as hardwired vs. rechargeable) with no other modifications, it would likely be deemed substantially equivalent. Similarly, if the material of the device were to change to another material known to be safe to the FDA, it is likely to be found substantially equivalent. A flowchart of the FDA decision making process has been included in the Appendix of this report.

However, there is a flaw with the approach of substantial equivalence. If a device is found to be unsafe after receiving market approval and then subjected to a recall, any *subsequent* devices which used the original, now-unsafe device as their predicate, are not subjected to any increased scrutiny or recalls. Recent analysis found that between the period of 2017 and 2021, the FDA initiated recalls of 156 devices using their highest risk categorization – devices with a reasonable probability to cause severe morbidity and mortality. Of those 156 devices recalled, 44.1 percent of them had received 510(k) approval using substantial equivalence to a device that had also been the subject of a recall.^{viii} Further, 48.1 percent of devices recalled within the studied period have themselves been used as the predicate for another device’s 510(k) approval. This post marketing safety information and related devices draw significant attention to potential problems with the current 510(k) approval process with a lack of criterion for granting approval for devices outside the most well-studied and well-understood.

Post-Market Surveillance

It should be noted that the study described above only studied a cohort of devices which were the subject of FDA-initiated recalls. There are likely a non-trivial number of devices that are still being used as comparators for substantial equivalence that have been found to be unsafe and then production halted or voluntarily recalled by the manufacturer. However, there is limited publicly available information to monitor this risk. This scenario highlights the importance of rigorous post-market surveillance for devices that have been approved using the 510(k) pathway.

Among the post-market surveillance activities required by the FDA is the reporting of adverse events. Under Medical Device Reporting regulations (Title 21 Code of Federal Regulations part 803), manufacturers, importers, and device user facilities (such as a hospital, nursing home or outpatient treatment facilities) are mandatory reporters to the FDA regarding serious device malfunction, including death. Reports are made to the device manufacturer (if known) and the FDA. Health care professionals, patients, and caregivers are able to report suspected adverse events for medical devices using the FDA’s MedWatch portal.

Adverse events are viewable to health care professionals and the public using the FDA’s Manufacturer and User Facility Device Experience (MAUDE) portal.^{ix} However, a 2019 exposé found that over 5 million incidents of reported adverse events were being kept from public view using an internal “alternative summary reporting” repository rather than the publicly available MAUDE database.^x Not only did this practice prevent physicians and patients from knowing the

real risks of currently approved medical devices, it also prevented manufacturers of new devices from knowing the risk profile of substantially similar predicate devices they were using for 510(k) approval. The FDA has stated that it has since abandoned this practice of internal incident report storage.^{xi}

Health Equity Considerations

It should also be noted that implicit in the 510(k) substantial equivalence method of approval is that it tends to maintain the status quo. For example, most, if not all, pulse oximeters currently used in the United States are approved via the 510(k) pathway.^{xii} Pulse oximeters estimate blood oxygen saturation by shining light through the skin, typically on a fingertip or an ear lobe. Oxygenated blood absorbs red light more efficiently than de-oxygenated blood, thus allowing for estimates of oxygenation by simply measuring the amount of red light that passes through a tissue. However, oxygenated blood is not the only thing that absorbs red light – melanin, melanosomes, and melanocytes (ie, skin pigmentation), also absorb or scatter red light. A retrospective study found that practitioners missed hypoxemia diagnoses in 11.7 percent of Black patients compared to 3.6 percent of white patients due to pulse oximetry overestimating blood oxygenation.^{xiii}

In the context of the COVID-19 pandemic, that suggests that excluding other factors, Black patients would be nearly 4-times less likely to receive oxygenation therapy such as a ventilator, which could prevent progression to acute respiratory distress syndrome.^{xiv} As a result of these findings, the FDA released a safety communication indicating oximeters may be less accurate in darker skin tones.^{xv} The failure of pulse oximeters to accurately measure oxygen saturation in all skin tones is a clear example of how inequity enters the health care system from many sources and can cascade. For example, even if a provider wished to start a patient on oxygenation therapy, Medicare reimbursement for supplemental oxygen therapy is only approved if a patient has a blood oxygenation reading less than or equal to 89 percent, which is less likely in Black patients if a pulse oximeter is used.^{xvi} In November 2022, the FDA hosted an advisory committee meeting to discuss concerns of pulse oximeters and skin pigmentation. Dr. Jesse Ehrenfeld, president-elect of the AMA, was a participant of this meeting and delivered comments and recommendations on behalf of the AMA.

It is important to assess whether approving a new pulse oximeter design that reaches the same level of performance as a predicate device is appropriate as our appreciation of inequity grows and some categories of devices no longer match the values we wish to uphold.

Off-Label Use of Medical Devices

While the FDA has attempted to pilot programs, such as the Safety and Performance Based Pathway, that would improve the balance of fostering innovation and patient safety, they may not have the legislative authority or resources available to make these new programs mandatory. Without authority to pursue reforms to medical device regulation, there are concerns that the FDA may become more and more likely to begin regulating the practice of medicine to achieve similar goals.

The FDA has the authority to ban medical devices if they present a substantial deception to patients about the benefits or an unreasonable and substantial risk of injury. However, there are recent concerns of misuse of the banning process. In 2020, the FDA published a rule banning the use of electrical stimulation devices (ESD) for the treatment of self-injurious and/or aggressive behavior.^{xvii} The FDA reported that the use of ESDs for this indication was unsafe and could lead to significant physical and psychological harm. ESDs were still approved for other indications such

as smoking cessation.^{xviii} The approval of devices for specific indications while banning the same device for others is, per AMA policy, the FDA regulating the practice of medicine. The AMA has extensive policy and significant history defending the rights of physicians to practice medicine and protect off-label prescribing of pharmaceuticals and devices.

Within the text of the FDA's rule on banning ESDs for aggressive behavior, they cite the 510(k) pathway as part of their justification for the banning of a specific indication, as they evaluate risk of a device based on its intended function, not on all potential functionalities. For example, daily wear vs. extended wear for gas permeable contact lenses are two separate risk categories. Evaluation of "substantially similar" for the purposes of 510(k) approval includes analysis of similar function. In 2021, the D.C. Circuit Court of Appeals overturned the ban, finding that the FDA was in fact regulating the practice of medicine, per the holdings of *Judge Rotenberg Educational Center v. United States Food and Drug Administration*.^{xix}

CONCLUSION

While the FDA has made strides in improving the 510(k) process for medical device approval, such as through the Safety and Performance Based Pathway, recent data have shown serious safety concerns. These safety concerns denote the need for the process to be re-examined to support the purpose and benefits of accelerated pathways along with providing the FDA with the statutory authority to address the larger, systemic issues without impeding on the practice of medicine.

RECOMMENDATIONS

The Council on Science and Public Health recommends the following be adopted, and the remainder of the report be filed:

1. Our AMA believes that to support innovation while protecting patient safety, approval pathways for medical devices should incorporate the following principles:
 - a. Evidence-based, measurable performance benchmarks, such as those used in the Safety and Performance Based Pathway, should be used wherever possible for classes of known, well-studied medical devices; and
 - b. For a subset of higher risk devices receiving approval but have not completed clinical trials, time-limited approvals may be appropriate, after which the manufacturer may be required to provide post-market data to support full device approval; and
 - c. Medical devices with known safety concerns should not be usable as predicate devices for the purposes of proving substantial equivalence. In the event safety concerns of predicate devices arise after approval has been granted, additional due diligence should be initiated as appropriate; and
 - d. Approval for medical devices should include criteria for adequate performance in racialized, minoritized, or otherwise historically excluded groups; and
 - e. Reports of adverse events for medical devices should always be available in a publicly accessible, searchable database such as the Manufacturer and User Facility Device Experience. (New HOD Policy)

2. That Policy H-120.988, "Patient Access to Treatments Prescribed by Their Physicians", supporting a physician's right to prescribe medical devices off-label, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal Note: less than \$1,000Appendix

TABLE 1

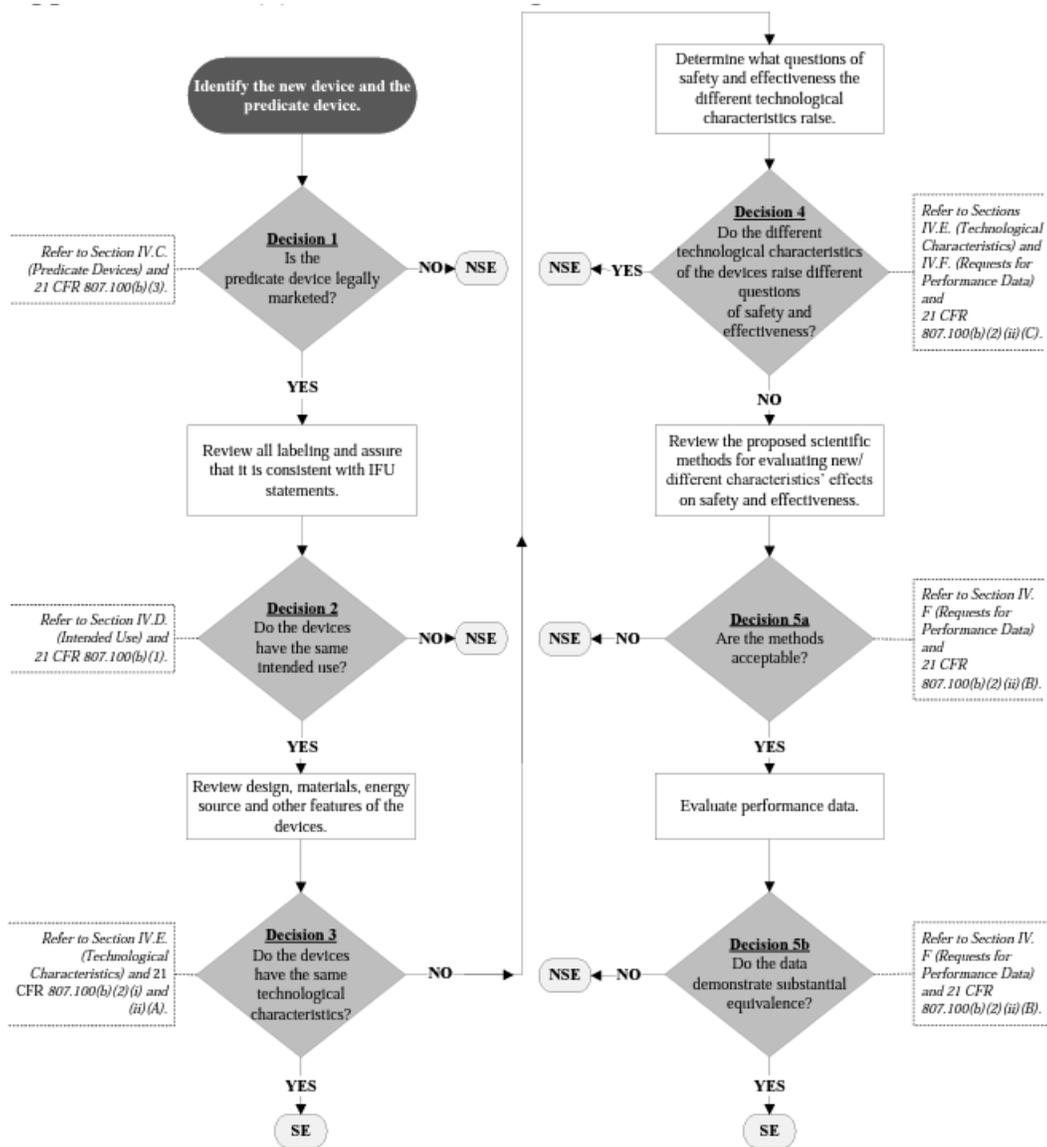
Comparison of regulatory requirements for drugs, biologics, and devices

Modified from Congressional Research Service, “Medical Product Regulation: Drugs, Biologics, and Devices”, published September 29th, 2021. <https://sgp.fas.org/crs/misc/IF11083.pdf>.

	Drug	Biologic	Class II (Medium Risk) Device	Class III (High Risk) Device
Authorization Type	Approval	Licensure	Clearance	Approval
Submission to FDA	New Drug Application	Biologics License Application	510(k) notification	Pre-market approval
Clinical Trials?	Yes	Yes	No	Yes (few exceptions)
Evidence Required by FDA	Substantial evidence of effectiveness, adequate evidence of safety	Substantial evidence of effectiveness, adequate evidence of safety	Substantial equivalence to a known, approved device	Reasonable assurance that the device is safe and effective for its intended use(s)

FDA 510(k) Decision-Making Flowchart

Modified from Food and Drug Administration, “The 510(k) Program: Evaluating Substantial Equivalence in Premarket Notifications [510(k)]”, July 28, 2014. Accessed January 23rd, 2023.



SE = "Substantially Equivalent"
 NSE = "Not Substantially Equivalent"
 IFU = "Indications For Use"

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 03-A-23

Subject: Regulation and Control of Self-Service Labs

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee E

1 At the 2022 Annual Meeting of the American Medical Association (AMA), the House of Delegates
2 adopted Policy D-260.992, “Regulation and Control of Self-Service Labs.” That directive called for
3 a study into “patient-directed self-service testing, including the accreditation and licensing of
4 laboratories that sell self-ordered tests and physician liability related to non-physician-ordered
5 tests”. This report serves as the Council on Science and Public Health’s (CSAPH) findings and
6 recommendations regarding self-service testing, also known as direct access testing (DAT) or
7 direct-to-consumer (DTC) testing. The Council has previously studied DTC genetic testing which
8 shares many issues with DAT. For the purposes of this report, DAT refers solely to non-genetic,
9 non-imaging based diagnostic testing.

10

11 METHODS

12

13 English language articles were selected from searches of PubMed and Google Scholar using the
14 search terms “direct access testing”, “self-service laboratory”, “direct to consumer laboratory”, and
15 “self-service laboratory AND liability”. Additional articles were identified by manual review of the
16 reference lists of pertinent publications. Web sites managed by government agencies and applicable
17 organizations were also reviewed for relevant information.

18

19 BACKGROUND

20

21 Patient-directed testing has existed in the United States for decades, such as over-the-counter
22 glucose testing kits available since the early 1980s. Currently, pharmacies sell a variety of at-home
23 tests for pregnancy, illicit drug use, or other biomarkers. However, starting in the late 2010s,
24 diagnostic companies began to offer a compilation of blood-based DATs such as hormone panels,
25 electrolytes, heavy metal screening, metabolic panels, and prostate specific antigen (PSA).
26 According to one estimate, the market for DAT in the United States currently exceeds \$350 million
27 per year, up from just \$15 million per year in 2010.¹ Another source estimates that the DTC genetic
28 and DAT lab services markets combined will exceed \$2.4 billion per year by 2025.² For the
29 purposes of this report, DAT will refer to medical tests that are not available as over-the-counter
30 kits and are performed by a laboratory after being purchased by an individual without a
31 prescription.

32

33 The DAT business model removes the health care professional, often the primary care physician,
34 from the care decision-making and allows an individual to directly purchase their test from the
35 laboratory. Overall, there is limited literature on DAT, the model, and outcomes for patients and
36 their care. According to the Frequently Asked Questions webpage of one DAT company, orders for
37 these tests are provided by a licensed clinician upon demand, but these tests are not reimbursed by
38 insurance as they are not the treating health care professional and they do not provide CPT codes.³

1
2 While the process may vary from company to company, they generally follow similar steps. First, a
3 patient is presented with a menu of available testing options. They then select the test(s) they would
4 like performed, and then pay up-front for the test. A licensed clinician then orders the test, which
5 the companies claim does not constitute a patient-physician relationship. The patient then visits a
6 nearby facility for their sample(s) to be taken, and they receive their results within a few days.
7 Results are often reported in the same manner as they would from a prescribed test in the usual
8 course of care— a single value with solely the reference range as context. Unlike tests that come
9 from a prescribing physician within a health-system, DAT companies do not provide any
10 diagnostic assessment, counseling, or guidance on laboratory results. Patients are encouraged to
11 share their results with their physicians, but it is unclear if or how any DAT facilities enter results
12 into the electronic medical record or otherwise to alert a health care professional that a test has
13 been performed.

14 15 DISCUSSION

16 17 *Patient Safety*

18
19 The most obvious concern around DAT is patient safety. Assuming the patient identifies an
20 appropriate test to measure the biomarker of interest, patients often receive a single numerical
21 value and a reference range for their test results with no additional description or suggested next
22 steps. However, interpreting medical tests is more than simply seeing if a number is within the
23 reference range. Physicians have years of training and experience to incorporate the quantitative
24 information of medical tests with the qualitative information collected from the patient, including
25 past medical history or signs and symptoms. Take for example the measurement of thyroid
26 stimulating hormone (TSH), which typically has a reference range listed of 1 to 4.5 mIU/L,
27 depending on the assay. A non-trained individual may receive a result of 4.3 mIU/L, see that it is
28 within the provided reference range, and assume they have healthy thyroid function. However, a
29 trained physician may recognize that in combination with presenting symptoms or other risk
30 factors, that this individual may have early hypothyroidism and can begin intervention.⁴

31
32 Risk assessment is a critical factor for interpreting and acting upon medical test results, but it is
33 also a key consideration for prescribing the test in the first place. For example, for PSA screening
34 the USPSTF recommends a shared decision-making model, in which men aged 55 to 69 should be
35 informed of the potential risks and benefits of PSA screening before making the decision with their
36 physician.⁵ PSA levels could be elevated from several non-cancer sources, such as benign prostatic
37 hyperplasia or prostatitis, and that the risk of dying from prostate cancer was approximately 2.5
38 percent. Studies have found that approximately 80 percent of men who pursued aggressive clinical
39 action such as brachytherapy due to elevated PSA levels experienced erectile dysfunction or
40 incontinence as a result of treatment.⁶ In recommending a screening one needs to consider the risks
41 of false positives and over-diagnosis of benign, non-fatal prostate cancers outweighed that may
42 outweigh benefits of early detection. USPSTF has found that PSA testing outside of a very specific
43 risk category offers poor or even negative value to the patient.⁷ This crucial risk-benefit analysis
44 and discussion is missing when an individual can simply order a PSA test from a DAT website and
45 may lead to unwanted outcomes. DAT companies do not follow any clinical guidelines for any test
46 provided. They do not limit test offerings to those in the appropriate risk categories.

47 48 *Legal Landscape*

49
50 While the definition varies from state to state, the practice of medicine is typically defined as
51 diagnosing, treating, or advising a patient on their symptoms or disease. It appears that DAT

1 companies are pursuing a loophole – if they explicitly do not advise a patient on what their test
2 results mean, or use a biomarker to diagnose, they contend it is not practicing medicine. Currently
3 37 states allow DAT with varying levels of restriction. It should be noted that depending on the
4 state, DAT companies might utilize a dentist, nurse practitioner, physician assistant, naturopathic
5 doctor, licensed acupuncturist, or chiropractor to order tests.

6
7 There are also concerns about the duty of the physician when a patient presents with DAT results
8 and requests their physician take clinical action. While the Council does not intend to offer clinical
9 guidance, it cannot identify any scenario in which the action by the physician, if they choose to act
10 at all, can be anything but re-ordering the test through appropriate channels. This is especially true
11 in instances where the patient may have ordered a test the physician is inexperienced with – how
12 can they be expected to act upon, and be liable for, a test they would not have ordered themselves?
13 Current AMA policy and the Code of Medical Ethics regarding direct-to-consumer diagnostic
14 imaging services states that any physician ordering a test is the responsible party for diagnosis and
15 subsequent patient counseling.⁸

16
17 Finally, there are also concerns about the regulations of the laboratories performing the tests. There
18 are two main ways in which clinical testing is regulated in the United States. First, if a test is fully
19 self-contained (ie, a test kit), then it is reviewed for medical claims by the Food and Drug
20 Administration (FDA) as an in vitro medical device. For all other medical testing, such as
21 laboratory developed tests, laboratories are regulated, inspected, and certified by the Centers for
22 Medicare and Medicaid Services (CMS) under the Clinical Laboratory Improvements Amendment
23 (CLIA). The FDA categorizes laboratory tests based on complexity, which CMS then uses to
24 develop regulations. Depending on the categorization of test complexity, CLIA may require quality
25 standards for facility administration, laboratory systems, personnel qualifications, quality
26 assessment, and quality control. CLIA certification is provided by CMS-approved accrediting
27 bodies, such as the Joint Commission or the College of American Pathologists. Studies have found
28 that the introduction of CLIA resulted in an increase in laboratory quality and customer
29 satisfaction.⁹

30
31 There have been reports that some companies offering DAT skirt the CLIA certification process by
32 claiming that since they only provide a context-free biomarker value, they are providing “health
33 information” rather than a medical test.¹⁰ Ensuring that these tests are performed in CLIA-certified
34 laboratories is critical for maintaining the accuracy of the results while also making sure patients’
35 samples and data are secure and stored appropriately.

36 37 *Examining the Appeal*

38
39 When assessing issues of DAT regulations, it is also important to understand the use-cases and
40 surrounding ecosystem that has caused the market for DATs to flourish. DAT marketing often
41 emphasizes a few key points: it is faster, the cost is upfront and known (ie, there is no unknown co-
42 pay that will be administered later), and that an individual will be able to take control over their
43 health. The first two claims are interconnected and point to the role health insurance companies
44 play in reimbursement for testing. For example, studies have shown that when individuals enroll in
45 a high deductible insurance plan, they are approximately 10 percent less likely to receive laboratory
46 tests due to the financial disincentive.¹¹ It is also important to recognize that an insurance provider
47 may require prior authorization, and then ultimately decline coverage, for outpatient laboratory
48 testing which adds significant delays and cost uncertainty for a patient.

49
50 Additionally, there are several tests offered by DAT companies for conditions which unfortunately
51 carry high levels of social stigma – particularly infectious diseases such as sexually transmitted

1 infections or hepatitis. In these instances, availability of a test which can be ordered online and
2 without an uncomfortable conversation with their physician may be attractive to many patients.
3 Tests for influenza or other respiratory viruses that can be ordered for home sample collection may
4 also reduce the risk of transmission in a hospital or clinic setting. However, those instances in
5 which DATs may be an appealing option further underscore the need for ensuring DAT facilities
6 are CLIA-certified and responsible for the appropriate patient counseling on result interpretation
7 and any necessary lifestyle changes.

8
9 Finally, DATs are often marketed to the individual who is seeking to better understand and control
10 their health. For example, DAT companies may offer cholesterol panel testing, which would be
11 appealing to someone who has changed their diet or exercise routine and is eager to see results.
12 While those goals should be applauded, there are multiple risks associated with this approach. First,
13 if the test is inaccurate, the individual will be given a false understanding of changes in their health.
14 Second, the individual may not properly understand the time it may take for their changes to have
15 an impact on a clinical biomarker, nor may they appreciate the healthy fluctuation the biomarker
16 levels may have from day-to-day, or the size of impact their lifestyle changes may have on the
17 biomarker. In some instances, an individual could discontinue medication or other treatments if
18 they are given inaccurate test results devoid of context. Again, this highlights the critical
19 importance of physician counseling in health management, as none of this information is currently
20 communicated to patients utilizing DAT companies.

21 22 CONCLUSION

23
24 In a system of complex insurance reimbursement and high out-of-pocket plans, DATs may appear
25 appealing for patients. However, current DAT practices appear to skirt regulatory requirements,
26 could easily be misinterpreted by patients, and lack appropriate diagnostic and counseling practices
27 by a physician. Potential utilization of DAT may be warranted in the realm of infectious disease
28 when immediate testing would be beneficial for public health; however, test results should still be
29 carefully communicated to the patient and monitored by a physician who is responsible for the
30 patient's care.

31 32 RECOMMENDATIONS

33
34 The Council on Science and Public Health recommends the following recommendations be
35 adopted, and the remainder of the report be filed:

- 36
37 1. Direct access testing, in which patients may order a diagnostic laboratory test on demand,
38 should only be provided by teams which are physician-led, and performed in facilities that
39 are CLIA-certified.
40
41 2. Health care professionals who offer direct access testing services, for which a patient does
42 not have a referral, recognize that agreeing to perform direct-to-consumer testing on
43 request:
44 a. establishes a patient relationship, with all the ethical and professional obligations
45 such relationship entails; and
46 b. assumes responsibility for relevant clinical evaluation, including pre- and post-test
47 counseling about the test, its results, and indicated follow-up. Health care
48 professionals may choose to refer the patient for post-test counseling to an
49 appropriate provider who accepts the patient, but they maintain ethical and
50 professional responsibility until the patient has been seen by that provider; and

1 shall report all required findings to relevant oversight entities, such as state public
2 health agencies, even if the patient and the laboratory are not co-localized in the
3 same jurisdiction. (New HOD Policy)
4

5 3. That Policy H-480.941, “Direct-to-Consumer Laboratory Testing,” calling for regulation of
6 direct-to-consumer testing and education of patients of risks and benefits, be reaffirmed.
7 (Reaffirmation of Current AMA Policy)

Fiscal Note: less than \$1,000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-23)

Introduced by: Medical Student Section

Subject: AMA Study of Chemical Castration in Incarceration

Referred to: Reference Committee E

1 Whereas, Chemical castration is defined as the use of pharmacologic agents, including anti-
2 antagonists and gonadotropin-releasing hormone agonists, to reduce serum testosterone
3 levels and quell libido in individuals diagnosed with a paraphilic disorder and other individuals
4 who commit sexual offenses, in an effort to reduce the occurrence of sexual offenses^{1,2}; and
5

6 Whereas, 4,984 people are currently incarcerated for sexual offenses in federal prisons^{3,4};
7 and
8

9 Whereas, Several states have passed or debated statutes requiring chemical castration for
10 individuals who commit sexual offenses as a sentence and/or as a requirement for parole,
11 most recently Alabama in 2019, where offenders are required to pay for their own treatment,
12 and in Tennessee in 2020^{1,5-8}; and
13

14 Whereas, Diagnostic and Statistical Manual of Mental Disorders (DSM)-V defines “paraphilic
15 disorder” as “recurrent and intense sexual arousal over a period of at least 6 months with
16 nonconsenting victims through voyeurism, exhibitionism, frotteurism, sexual sadism, and
17 pedophilia” and estimated lifetime prevalences are 12% for males and 4% for females⁹; and
18

19 Whereas, Chemical castration can be traced to the 1900s eugenics movement where people
20 with developmental delays and psychiatric diagnoses were forcibly sterilized, including up to
21 60,000 incarcerated women diagnosed with and intellectual disability¹; and
22

23 Whereas, Chemical castration via injection with Depo-Provera (medroxyprogesterone
24 acetate) and surgical sterilization have historically disproportionately targeted Black
25 individuals in the United States, including the deceptive, experimental testing of Depo-
26 Provera as a method of birth control on young Black females in the 1960s^{10,11}; and
27

28 Whereas, The current method of chemical castration for incarcerated males who committed
29 sex offenses in several states, including California and Florida, is via injection with Depo-
30 Provera, although no medication, including Depo-Provera, is currently FDA-approved for
31 chemical castration¹²; and
32

33 Whereas, Limited evidence exists for the effectiveness of chemical castration, with several
34 studies noting that chemical castration does not address the core psychological impulses
35 relating to sexually aberrant behavior^{12,13}; and
36

37 Whereas, When chemical castration is a requirement for parole, judges, not medical doctors,
38 are charged with deciding whether or not a prisoner receives chemical castration therapy,
39 suggesting that chemical castration constitutes punishment instead of rehabilitative therapy¹²;
40 and

1 Whereas, The Association for the Treatment of Sexual Abusers (ATSA) published a 2012
2 statement on the use of chemical castration for individuals with paraphilic disorders and
3 individuals who commit sexual offenses, concluding that chemical castration may be effective
4 for certain patients when combined with other non-pharmacologic interventions such as
5 psychotherapy¹⁴; and
6

7 Whereas, The issue of chemical castration is rife with ethical quandaries and valid arguments
8 may exist both in support of and in opposition to this practice¹⁵; and
9

10 Whereas, In situations where chemical castration is a requirement for parole, some may
11 argue that this requirement unjustly coerces an individual to agree to a medical procedure,
12 while others may argue that if chemical castration was not required, an individual may never
13 be allowed the possibility of parole at all and may remain incarcerated¹⁵; and
14

15 Whereas, Scientific research, medical information, and expert opinions from physicians on
16 the issue of chemical castration for individuals who commit sexual offenses, especially in the
17 last 5 years, are difficult to find most likely since the population affected by chemical
18 castration have not been the subject of much retrospective research; and
19

20 Whereas, The American Psychiatric Association raised concerns in July 2021 about the use
21 of chemical castration as a condition for parole, citing ethical concerns over the minimal to
22 absent involvement of physicians and calling the “court-driven, one-size-fits-all approach to
23 anti-androgen treatment inconsistent with contemporary medical practice”¹⁶; and
24

25 Whereas, Our American Medical Association previously adopted Policy 140.955, “Court-
26 Ordered Castration,” which stated that “The AMA opposes physician participation in
27 castration and other surgical or medical treatments initiated solely for criminal punishment,”
28 but this policy was later rescinded due to being considered duplicative of Code of Medical
29 Ethics Opinion 9.7.2, “Court-Initiated Medical Treatment in Criminal Cases”¹⁷⁻¹⁸; and
30

31 Whereas, While the AMA Code of Medical Ethics Opinion 9.7.2 states that “physicians who
32 provide care under court order should: (a) Participate only if the procedure being mandated is
33 therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a
34 mechanism of social control,” the morality of chemical castration under this Code is unclear,
35 including its use as efficacious treatment, as a mechanism for social control, as a tool for
36 public safety, and as an alternative to incarceration^{1,5-8,15,18}; therefore be it
37

38 RESOLVED, That our American Medical Association study the use of chemical castration in
39 the treatment of incarcerated individuals with paraphilic disorders and for other individuals
40 who commit sexual offenses, including ethical concerns over coercion in its use as an
41 alternative to incarceration and in probation and parole proceedings. (Directive to Take
42 Action)
43

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

Received: 3/31/23

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RELEVANT AMA POLICY

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an

independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

Issued: 2016

Informed Consent, E-2.1.1

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

Issued: 2016

Patient-Physician Relationships, E-1.1.1

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

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

Issued: 2016

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Citation: 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; Modified: CSAPH Rep. 1, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-23)

Introduced by: Medial Student Section

Subject: Pain Management for Long-Acting Reversible Contraception and other
Gynecological Procedures

Referred to: Reference Committee E

1 Whereas, A U.S.-based prospective study of over 9,256 women known as the Contraceptive
2 CHOICE Project showed that increasing access to long-acting reversible contraceptives
3 (LARC) will lead to a decrease in both unintended pregnancies and annual healthcare costs¹;
4 and

5
6 Whereas, AMA policy H-75.987 supports a national goal of reducing unintended pregnancies
7 via counseling women of children bearing age on family planning and LARC use; and
8

9 Whereas, Intrauterine devices (IUDs) are between 99.6% and 99.9% effective as long-acting
10 reversible contraceptives and 99.9% effective as emergency contraceptives^{2,3}; and
11

12 Whereas, The 2017-2019 National Survey of Family Growth states that 10.4% of women age
13 15-49 in the United States use long-acting reversible contraceptives and use of LARCs has
14 risen five-fold in the last decade among women aged 15-44^{4,5}; and
15

16 Whereas, Without the use of analgesics or anesthesia, nearly 89% of women report
17 moderate to severe pain during placement of a tenaculum, which precedes insertion of an
18 intrauterine device (IUD), removal of lost IUDs, as well as endometrial biopsy, uterine
19 aspiration, colposcopy, and hysteroscopy⁶; and
20

21 Whereas, A 2014 study found that, on a scale of 100, the mean patient maximum pain upon
22 IUD insertion was 64.8 compared to 35.3 rated by the physician, highlighting a discrepancy
23 between patients' experienced pain and providers' assumption of pain⁷; and
24

25 Whereas, Studies report that physicians often underestimate female pain and treat female
26 pain less extensively than male pain; consequently, physicians are less likely to recommend
27 analgesics and are more likely to recommend psychological treatment for female pain than
28 for male pain⁸⁻¹³; and
29

30 Whereas, In addition to LARC insertion procedures, a substantial portion of other gynecologic
31 procedures are routinely performed in offices and in clinics, including colposcopy with biopsy,
32 loop electrosurgical excision procedure (LEEP), endometrial biopsy, uterine aspiration,
33 dilation and evacuation (D&E), saline infusion sonogram, and hysterosalpingogram, among
34 others under circumstances with limited validated options for analgesia¹⁴; and
35

36 Whereas, Local anesthesia, general anesthesia, and oral or intravenous sedation is
37 commonly used in vasectomy procedures for pain control and clear guidelines regarding use
38 of sedation or anesthesia for vasectomies are explicitly outlined in American Urological
39 Association clinical guidelines¹⁵; and

1 Whereas, Studies have shown that medical professionals hold false beliefs about Black
2 people feeling less pain, so that Black women stand to face compounded effects of racism
3 and sexism when seeking appropriate treatment for pain¹⁶; and
4

5 Whereas, Current research suggests that anticipated pain is correlated with increased
6 perceived pain throughout the duration of IUD insertion, especially in marginalized
7 populations¹⁷; and
8

9 Whereas, While studies have shown LARCs to be associated with high rates of satisfaction
10 following insertion, this level of satisfaction is negatively impacted by pain experienced during
11 the procedure¹⁸; and
12

13 Whereas, Negative experiences related to gynecologic procedures may lead to patients
14 delaying otherwise routine gynecologic care, which can lead to preventable healthcare
15 inequities surrounding undiagnosed gynecological cancers, endometriosis, infections,
16 thereby impacting a patient's quality of life and potentially resulting in preventable death¹⁹;
17 and
18

19 Whereas, Multiple analgesic treatment regimens, including prophylactic NSAIDs, cervical
20 ripening, and topical cervical lidocaine, have been shown to provide inadequate analgesia prior
21 to IUD insertion, while intracervical lidocaine block and ketorolac injection have demonstrated
22 potential analgesic efficacy around the time of IUD insertion²⁰⁻²³; and
23

24 Whereas, Adequate management of postoperative pain after gynecologic procedures has
25 been associated with fewer postoperative hospital admissions²⁴; and
26

27 Whereas, The American College of Obstetricians and Gynecologists (ACOG) acknowledges
28 that, of the patients that undergo IUD insertion, “many report moderate to severe pain” and
29 that more research is needed to identify effective options to reduce pain for IUD insertion²⁵;
30 and
31

32 Whereas, ACOG specifically recommends that physicians consider analgesia or sedation for
33 women who are at higher risk for increased pain during IUD insertion, such as nulliparous
34 women, patients requiring cervical dilation, or patients who have had a past painful insertion
35 experience²⁵; and
36

37 Whereas, Our American Medical Association endorses training physicians on adequate pain
38 control and urges for informed consent for other in-office procedures such as policy H-69.945
39 “Neonatal Male Circumcision”, but does not have a policy that explicitly discusses pain
40 management for gynecological procedures; therefore be it
41

42 RESOLVED, That our American Medical Association recognize the disparity in pain
43 management in gynecological procedures compared to procedures of similarly reported pain
44 and encourages discussion of pain control options, risks, and benefits with patients as a part of
45 the shared decision making process (New HOD Policy); and be it further
46

47 RESOLVED, That our AMA support further research into evidence-based anesthetic and
48 anxiolytic medication options for long-acting reversible contraception procedures and other
49 gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and
50 LEEP procedures. (New HOD Policy)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16;

Pain Management H-410.950

Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and

in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

Citation: (BOT Rep. 16, A-13)

Coverage of Contraceptives by Insurance H-180.958

1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.

2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.

Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17;

Modified: BOT Rep. 10, A-18;

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;

(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;

(3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;

(4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);

(5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);

(6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;

(7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;

(8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;

(9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and

(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.

3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 401, A-19;

Neonatal Male Circumcision H-60.945

1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for

families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.

2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.

Citation: (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)

E2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of **informed consent** occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's **informed consent** (or the **consent** of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the **informed consent** conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written **consent**, the **consent** form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior **informed consent**. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain **consent** for ongoing treatment in keeping with these guidelines.

Issued: 2016

Pain as the Fifth Vital Sign D-450.956

Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.

Citation: BOT Rep. 19, A-16; Reaffirmation: A-19;

H-515.952 Adverse Childhood Experiences and Trauma-Informed Care

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);

b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;

c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.

d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and

e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and

f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with

significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Citation: Res. 504, A-19; Appended: CSAPH Rep. 3, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-23)

Introduced by: Medical Student Section

Subject: Increasing Diversity in Stem Cell Biobanks and Disease Models

Referred to: Reference Committee E

1 Whereas, Despite racial and ethnic minorities composing almost 40% of the U.S. population,
2 most biomedical and clinical research uses a largely homogenous population that is usually
3 79.7% White, with 98% of over 10,000 NIH-funded cancer clinical trials not meeting NIH's
4 own criteria and goals for minority participation¹⁻³; and

5
6 Whereas, A principal component analysis of embryonic stem cell lines from the 1000
7 Genomes Project discovered 93 percent of 143 sequenced human embryonic stem cell lines
8 clustered with reference samples of European ancestry⁴; and

9
10 Whereas, An analysis of 555 completed stem cell clinical trials showed only 45%
11 documented information regarding patients' race and ethnicity, of which, Native American or
12 Alaskan, Black, and Multiracial groups were underrepresented when compared to U.S.
13 population data⁵; and

14
15 Whereas, Given that 72.6% of induced pluripotent stem cell lines (iPSCs) are Caucasian in
16 origin, there is limited availability of racially and ethnically diverse iPSC biobanks and patient-
17 derived disease models⁵⁻⁷; and

18
19 Whereas, The availability of diverse iPSC lines has not kept pace with advances in iPSC
20 disease models and technologies, leading to biased insights on disease mechanisms,
21 disease susceptibility, and drug responses in population-specific genetic variants⁷⁻¹¹; and

22
23 Whereas, The history of research involving minorities has included questionable and harmful
24 actions, such as the 1932 Tuskegee Syphilis Study, resulting in a greater unwillingness
25 among minorities to participate in research studies^{12,13}; and

26
27 Whereas, Recruitment materials used in U.S. biobanks are predominantly in English and
28 above a fifth-grade reading level, limiting participation by underrepresented populations¹⁴;
29 and

30
31 Whereas, Biobank recruitment strategies are often convenience-based, with hospital-based
32 researchers recruiting patients not representative of those most afflicted by disease¹²; and

33
34 Whereas, Exclusion criteria in clinical trials often leads to participants with characteristics that
35 are skewed, and the unnecessary exclusion of participants (e.g. non-English speakers,
36 people with mental and physical disabilities), that better represent the actual demographic
37 after treatment approval^{15,16}; and

1 Whereas, Lack of diverse iPSC models for drug toxicity assessments fails to account for
2 variations in metabolic activity, which leads to higher rates of adverse events in minority
3 populations, resulting in patient harm and waste of resources^{9,17}; and
4

5 Whereas, Existing studies investigating the diversity of stem cell research encompass only
6 major racial and ethnic groups (e.g. Asian or Latino), despite health disparities existing
7 among specific subgroups (e.g. Cambodian or Colombian)^{6,18}; and
8

9 Whereas, An initiative by California's Stem Cell Agency addresses gaps in the diversity of
10 stem cell lines through its publicly accessible iPSC Repository, with 2,600 iPSCs lines
11 inclusive of minority populations including African, Hispanic, Native American, and East and
12 South Asian populations¹⁹; and
13

14 Whereas, The NIH-sponsored All of Us Research Program endorses diversity as a core
15 value and aims to build one of the largest diverse biobanks²⁰; and
16

17 Whereas, Our American Medical Association supports the Diversity Trials Act that strives to
18 ensure clinical trials focus on diseases disproportionately impacting underrepresented
19 populations to discover scientific advances benefiting all communities²¹; and
20

21 Whereas, A recent study from the Stanford University Center for Biomedical Ethics (SCBE)
22 recommends that reviewers and editors give priority to manuscripts that have significant
23 minority group representation and to those that replicate prior studies that were primarily
24 focused on White populations^{22,23}; and
25

26 Whereas, A recent study SCBE recommends that race and/or ethnicity be included as
27 variables in experiments requiring the use of stem cell lines such that potentially variable
28 outcomes of intervention between racial or ethnic groups can be assessed^{23,24}; and
29

30 Whereas, Our AMA is committed to supporting stem cell research and its diversification
31 through a number of methodologies, as described in H-460.911, H-460.915, H-460.889, H-
32 460.924, and 7.3.8 Research with Stem Cells²⁴⁻²⁶; therefore be it
33

34 RESOLVED, That our American Medical Association encourage research institutions and
35 stakeholders to re-evaluate recruitment strategies and materials to encourage participation
36 by underrepresented populations (New HOD Policy); and it be further
37

38 RESOLVED, That our AMA amend Policy H-460.915, "Cloning and Stem Cell Research," by
39 addition to read as follows:
40

41 **Cloning and Stem Cell Research, H-460.915**

42 Our AMA: (1) supports biomedical research on multipotent
43 stem cells (including adult and cord blood stem cells); (2) urges
44 the use of stem cell lines from different ethnicities in disease
45 models; ~~(2)~~(3) supports the use of somatic cell nuclear transfer
46 technology in biomedical research (therapeutic cloning); ~~(3)~~(4)
47 opposes the use of somatic cell nuclear transfer technology for
48 the specific purpose of producing a human child (reproductive
49 cloning); ~~(4)~~(5) encourages strong public support of federal

1 funding for research involving human pluripotent stem cells and
2 ~~(5)~~(6) will continue to monitor developments in stem cell
3 research and the use of somatic cell nuclear transfer
4 technology (Modify Current HOD Policy); and be it further
5

6 RESOLVED, That our AMA strongly encourage institutional biobanks to collect racially and
7 ethnically diverse samples such that future induced pluripotent stem cell disease models
8 better represent the population. (New HOD Policy)
9

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

Received: 3/31/23

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RELEVANT AMA POLICY

Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research H-460.911

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22;

Cloning and Stem Cell Research H-460.915

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology.

Citation: (CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Support of Embryonic/Pluripotent Stem Cell Research H-460.889

Our AMA will encourage strong public support of federal funding for research involving human pluripotent stem cells.

Citation: CSAPH Rep. 01, A-19;

E-7.3.8 Research with Stem Cells

Human **stem cells** are widely seen as offering a source of potential treatment for a range of diseases and are thus the subject of much **research**. Clinical studies have validated the use of adult **stem cells** in a limited number of therapies, but have yet to confirm the utility of embryonic **stem cells**.

Physicians who conduct **research** using **stem cells** obtained from any source (established tissue, umbilical cord blood, or embryos) must, at a minimum:

- (a) Adhere to institutional review board (IRB) requirements.
- (b) Ensure that the **research** is carried out **with** appropriate oversight and monitoring.
- (c) Ensure that the **research** is carried out **with** appropriate informed consent. In addition to disclosure of **research** risks and potential benefits, at minimum, the consent disclosure should address:
 - (i) for a donor of **cells** to be used in **stem cell research**:
 - a. the process by which **stem cells** will be obtained;
 - b. what specifically will be done **with** the **stem cells**;
 - c. whether an immortal cell line will result; and
 - d. the primary and anticipated secondary uses of donated embryos and/or derived **stem cells**, including potential commercial uses.
 - (ii) for a recipient of **stem cells** in clinical **research**:
 - a. the types of tissue from which the **stem cells** derive (e.g., established tissue, umbilical cord blood, or embryos); and
 - b. unique risks posed by investigational **stem cell** products (when applicable), such as tumorigenesis, immunological reactions, unpredictable behavior of **cells**, and unknown long-term health effects.

The professional community as well as the public remains divided about the use of embryonic **stem cells** for either **research** or therapeutic purposes. The conflict regarding **research with** embryonic **stem cells** centers on the moral status of embryos, a question that divides ethical opinion and that cannot be resolved by medical science. Regardless whether they are obtained from embryos donated by individuals or couples undergoing in vitro fertilization, or from cloned embryos created by somatic cell nuclear transfer (SCNT), use of embryonic **stem cells** currently requires the destruction of the human embryo from which the **stem cells** derive.

The pluralism of moral visions that underlies this debate must be respected. Participation in **research** involving embryonic **stem cells** requires respect for embryos, **research** participants, donors, and recipients. Embryonic **stem cell research** does not violate the ethical standards of the profession. Every physician remains free to decide whether to participate in **stem cell research** or to use its products.

Physicians should continue to be guided by their commitment to the welfare of patients and the advancement of medical science.

Physicians who conduct **research** using embryonic **stem cells** should be able to justify greater risks for subjects, and the greater respect due embryos than **stem cells** from other sources, based on expectations that the **research** offers substantial promise of contributing significantly to scientific or therapeutic knowledge.

Issued: 2016

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our

AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 01, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-23)

Introduced by: American Society for Surgery of the Hand, American Association
of Hand Surgery

Subject: Regulating Misleading AI Generated Advice to Patients

Referred to: Reference Committee E

- 1 Whereas, A generative pretrained transformer (GPT) is an AI tool that produces text resembling
2 human writing, allowing users to interact with AI almost as if they are communicating with
3 another person; and
4
5 Whereas, GPT is prone to errors and omissions that can fail at simple tasks, such as basic
6 arithmetic, or insidiously commit errors that go unnoticed without scrutiny by subject matter
7 experts; and
8
9 Whereas, Patients might benefit from using GPT as a medical resource; however, unless its
10 advice is filtered through health care practitioners, false or misleading information could
11 endanger their safety; and
12
13 Whereas, When consumers directly ask AI for emotional support or medical advice, they act
14 outside the patient-physician relationship, and few guardrails exist; and
15
16 Whereas, Most health care laws do not apply in the consumer context, however, the Federal
17 Trade Commission (FTC) could designate false and misleading AI-generated medical advice as
18 *unfair or deceptive business practices* that violate the FTC act, and the US Food and Drug
19 Administration could hold software developers responsible if GPT makes false medical claims;
20 therefore be it
21
22 RESOLVED, That our American Medical Association commence a study of the benefits and
23 unforeseen consequences to the medical profession of GPTs, with report back to the HOD at
24 the 2023 interim meeting (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA consider working with the Federal Trade Commission and other
27 appropriate organizations to protect patients from false or misleading AI-generated medical
28 advice (Directive to Take Action); and be it further
29
30 RESOLVED, That our AMA encourage physicians to educate our patients about the benefits
31 and risks of consumers facing generative pretrained transformers. (New HOD Policy)

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

Received: 4/2/23

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DOI:10.1001/JAMA.2023.5321

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-23)

Introduced by: Medical Student Section

Subject: Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations

Referred to: Reference Committee E

- 1 Whereas, In the United States, the opioid epidemic is a growing health crisis and has been
2 declared a public health emergency¹; and
3
- 4 Whereas, Natural opioids are derived from the poppy plant, such as morphine and codeine,
5 while synthetic opioids are artificially synthesized such as fentanyl, carfentanil, and
6 methadone²; and
7
- 8 Whereas, Natural and synthetic opioid overdose-related deaths are a significant cause of
9 death in the U.S., contributing to more than 100,000 deaths from April 2020 to April 2021, a
10 28.5% increase from the year prior^{3,4}; and
11
- 12 Whereas, Naloxone is a competitive antagonist with a high affinity for the mu-opioid receptor
13 that can reverse opioid-induced respiratory depression and rescue opioid overdose, with a
14 half-life of 30 to 120 minutes⁵; and
15
- 16 Whereas, The widespread distribution and use of naloxone has been shown to decrease
17 opioid overdose-related deaths without significantly increasing the incidence of opioid use⁶⁻⁸;
18 and
19
- 20 Whereas, Naloxone may precipitate withdrawal, which can lead to physical and psychological
21 side effects for the patient, including mood changes, which may adversely affect bystanders
22 or medical staff^{9,10}; and
23
- 24 Whereas, The need for large or repeated doses of naloxone to reverse synthetic opioid
25 overdose further complicates medical management, adding to healthcare worker stress,
26 especially in times of shortage¹¹; and
27
- 28 Whereas, Patients who overdosed on fentanyl-adulterated opioid tablets who received
29 naloxone had recurrence of respiratory depression beyond the standard observation period
30 for opioid overdose¹²; and
31
- 32 Whereas, Synthetic opioids have an increased potency compared to natural opioids, which
33 frequently necessitates higher initial dosing or additional administrations to rescue respiratory
34 depression in the setting of overdose¹³⁻¹⁵; and
35
- 36 Whereas, It has been estimated that nearly 80% of fatal opioid-related overdose deaths
37 involved synthetic opioids¹⁶; and

1 Whereas, Between 2013 and 2019, synthetic opioid overdose-related deaths increased
2 1,040%, with more than 55,000 deaths related to synthetic opioid overdose in 2020 alone¹⁷⁻
3 ¹⁹; and
4

5 Whereas, A multi-agency meeting was held in 2019 to discuss the threat of synthetic opioids
6 and urge the development of drugs aimed at rescuing respiratory depression and overdose
7 caused by synthetic opioids specifically; among those present were representatives from the
8 National Institutes of Health (NIH), the National Institute of Allergy and Infectious Diseases,
9 the National Institute of Drug Abuse, the Food and Drug Administration (FDA), the Chemical
10 Countermeasures Research Program, the Biomedical Advanced Research and Development
11 Authority, and the Defense Threat Reduction Agency²⁰; and
12

13 Whereas, Respiratory stimulant drugs such as hypothalamic hormones, nicotinic receptor
14 agonists, ampakines, serotonin agonists, antioxidants, and potassium channel blockers have
15 been used in animal studies to reverse opioid-induced respiratory depression as alternatives
16 to naloxone, but require further study before safe clinical use^{11,21,22}; and
17

18 Whereas, Preliminary studies of nalmefene, a mu-opioid receptor antagonist more potent
19 than nalcen, have shown potential reversal of opioid-induced respiratory depression²²; and
20

21 Whereas, Experimental drugs such as methocinnamox, an opioid receptor antagonist, have
22 been shown to prevent respiratory depression following heroin exposure in Rhesus monkeys,
23 but have not yet reached clinical trials²³; and
24

25 Whereas, Approximately 1 in 4 women on Medicaid were prescribed opioids during
26 pregnancy²⁴; and
27

28 Whereas, This high level of opioid use during pregnancy correlates with increased incidence
29 of neonatal abstinence syndrome (NAS) among babies, which is a group of psychological
30 and neurobehavioral signs of withdrawal that may occur in a newborn exposed to opioids or
31 psychotropic substances in utero that between 50% to 80% of infants exposed to opioids in
32 utero will develop^{24,25}; and
33

34 Whereas, Barriers to treatment for pregnant women with opioid use disorder (OUD) include
35 legal consequences, shame associated with opioids, and misinformation among healthcare
36 professionals resulting in reluctance to provide care²⁵; and
37

38 Whereas, The American College of Obstetricians and Gynecologists (ACOG) recommends
39 screening for substance use as a part of comprehensive obstetric care, and further
40 recommends that screening should be done at the first prenatal visit universally for all
41 patients²⁶; and
42

43 Whereas, The American Academy of Addiction Psychiatry (AAP) supports voluntary
44 screening of pregnant women for substance use disorders for the purpose of providing
45 prenatal care and treatment to mother and fetus²⁷; and
46

47 Whereas, Universal screening rather than targeted or risk-based screening, as targeted
48 screening can be influenced by negative stereotyping, and may disproportionately target
49 marginalized communities²⁹; and

1 Whereas, A large systematic review of non-randomized trials found that take-home naloxone
2 programs have led to improved survival rates among program participants and reduced
3 opioid overdose mortality rates in the community, and are accompanied by only a low rate of
4 adverse events²⁸; and

5
6 Whereas, The rate of opioid overdose-related inpatient stays in rural areas increased 76.3%
7 between 2010 and 2017³⁰; and

8
9 Whereas, The rate of overdose deaths involving opioids among American Indian and Alaskan
10 Natives increased from 2.2 deaths per 100,000 individuals in 2000 to 13.7 deaths per
11 100,000 individuals in 2016³¹; and

12
13 Whereas, A recent systematic review illustrated the need to manage opioid use disorder
14 (OUD) in rural American Indian / Alaskan Native communities with harm reduction education
15 and medication assisted treatment³²; and

16
17 Whereas, The United States Department of Health and Human Services identifies naloxone
18 distribution as a top harm-reduction strategy for addressing the opioid epidemic³³; and

19
20 Whereas, Recent studies of naloxone access in rural areas have identified common barriers,
21 including cost, distance to clinics and providers, stigma felt by customers asking for
22 naloxone, and unawareness of current state-specific standing-order laws³⁴⁻³⁷; and

23
24 Whereas, Medicare Part D, the largest single payer of naloxone prescriptions in the United
25 States, dispensed naloxone at a rate of 4.9 per 1000 enrollees compared to 2.9 per 1000
26 enrollees in non-metropolitan areas, suggesting a growing disparity in naloxone availability in
27 rural areas³⁸; and

28
29 Whereas, A CDC's August 2019 *Vital Signs* report noted that the amount of naloxone
30 dispensed is 25 times greater in the highest-dispensing counties compared to the lowest-
31 dispensing counties, and that rural counties in the United States are 3 times more likely to be
32 a low-dispensing county than in metropolitan areas³⁹; and

33
34 Whereas, A study found Arizona was the only state that had enough naloxone availability to
35 prevent 80% of witnessed overdoses in 2017⁴⁰; and

36
37 Whereas, Stigma towards drug use in public pharmacy spaces – including fear of naloxone
38 customers being stereotyped as an “addict” and discomfort of pharmacy staff introducing the
39 subject of naloxone – is a recurrent finding in studies examining challenges of naloxone
40 distribution^{37,41-43}; and

41
42 Whereas, The stigmatization of purchasing medications may be reduced with telehealth and
43 mail-order options for naloxone prescription and delivery⁴⁴; and

44
45 Whereas, Numerous studies, models, and systematic reviews of the literature have
46 demonstrated take-home naloxone programs reduce opioid overdose mortality⁴⁵⁻⁵¹; and

47
48 Whereas, Our American Medical Association supports legal use of naloxone regardless of
49 prescription status (H-95.932); and

1 Whereas, Our AMA already has clear policy (H-420.950 and H-420.962) addressing the key
2 legal, ethic and social concerns around substance use disorder in pregnancy and perinatal
3 addiction, but lacks policy specifically supporting universal screening for opioid use as a tool
4 to combat substance use disorder in pregnancy; and
5

6 Whereas, AMA policy advocates for the prevention of drug-related overdose (D-95.987) and
7 general opioid mitigation (D-95.964), but does not explicitly address the growing concern of
8 synthetic opioids nor the limitations of naloxone; therefore be it
9

10 RESOLVED, That our American Medical Association amend Policy H-95.932, "Increasing
11 Availability of Naloxone", by addition to read as follows:
12

13 **Increasing Availability of Naloxone H-95.932**

- 14 1. Our AMA supports legislative, regulatory, and national
15 advocacy efforts to increase access to affordable naloxone,
16 including but not limited to collaborative practice agreements
17 with pharmacists and standing orders for pharmacies and,
18 where permitted by law, community-based organizations, law
19 enforcement agencies, correctional settings, schools, and other
20 locations that do not restrict the route of administration for
21 naloxone delivery.
- 22 2. Our AMA supports efforts that enable law enforcement
23 agencies to carry and administer naloxone.
- 24 3. Our AMA encourages physicians to co-prescribe naloxone to
25 patients at risk of overdose and, where permitted by law, to the
26 friends and family members of such patients.
- 27 4. Our AMA encourages private and public payers to include all
28 forms of naloxone on their preferred drug lists and formularies
29 with minimal or no cost sharing.
- 30 5. Our AMA supports liability protections for physicians and
31 other healthcare professionals and others who are authorized
32 to prescribe, dispense and/or administer naloxone pursuant to
33 state law.
- 34 6. Our AMA supports efforts to encourage individuals who are
35 authorized to administer naloxone to receive appropriate
36 education to enable them to do so effectively.
- 37 7. Our AMA encourages manufacturers or other qualified
38 sponsors to pursue the application process for over the counter
39 approval of naloxone with the Food and Drug Administration.
- 40 8. Our AMA supports the widespread implementation of easily
41 accessible Naloxone rescue stations (public availability of
42 Naloxone through wall-mounted display/storage units that also
43 include instructions) throughout the country following
44 distribution and legislative edicts similar to those for Automated
45 External Defibrillators.
- 46 9. Our AMA supports the legal access to and use of naloxone
47 in all public spaces regardless of whether the individual holds a
48 prescription.
- 49 10. Our AMA supports efforts to increase the availability,
50 delivery, possession and use of mail-order naloxone to help

1 prevent opioid-related overdose, especially in underserved
2 communities and American Indian reservations. (Modify
3 Current HOD Policy)

4 and be it further

5
6 RESOLVED, That our AMA amend Policy H-420.950, "Substance Use Disorders During
7 Pregnancy" by addition to read as follows:

8
9 **Substance Use Disorders During Pregnancy H-420.950**

10 Our AMA will: (1) oppose any efforts to imply that the diagnosis
11 of substance use disorder during pregnancy represents child
12 abuse; (2) support legislative and other appropriate efforts for
13 the expansion and improved access to evidence-based
14 treatment for substance use disorders during pregnancy; (3)
15 oppose the removal of infants from their mothers solely based
16 on a single positive prenatal drug screen without appropriate
17 evaluation; ~~and~~ (4) advocate for appropriate medical evaluation
18 prior to the removal of a child, which takes into account (a) the
19 desire to preserve the individual's family structure, (b) the
20 patient's treatment status, and (c) current impairment status
21 when substance use is suspected, and (5) support universal
22 opioid use screenings at prenatal care visits with early
23 intervention, comprehensive naloxone use education and
24 distribution for those who screen positive and following
25 overdose-related emergency department visits. (Modify Current
26 HOD Policy)

27 and be it further

28
29 RESOLVED, That our AMA amend D-95.987, "Prevention of Drug-Related Overdose" by
30 addition to read as follows:

31
32 **Prevention of Drug-Related Overdose D-95.987**

33 1. Our AMA: (a) recognizes the great burden that substance
34 use disorders (SUDs) and drug-related overdoses and death
35 places on patients and society alike and reaffirms its support for
36 the compassionate treatment of patients with a SUD and
37 people who use drugs; (b) urges that community-based
38 programs offering naloxone and other opioid overdose and
39 drug safety and prevention services continue to be
40 implemented in order to further develop best practices in this
41 area; (c) encourages the education of health care workers and
42 people who use drugs about the use of naloxone and other
43 harm reduction measures in preventing opioid and other drug-
44 related overdose fatalities; and (d) will continue to monitor the
45 progress of such initiatives and respond as appropriate.
46 2. Our AMA will: (a) advocate for the appropriate education of
47 at-risk patients and their caregivers in the signs and symptoms
48 of a drug-related overdose; ~~and~~ (b) support the development of
49 adjuncts and alternatives to naloxone to combat synthetic
50 opioid-induced respiratory depression and overdose; and (c)

- 1 encourage the continued study and implementation of
2 appropriate treatments and risk mitigation methods for patients
3 at risk for a drug-related overdose.
4 3. Our AMA will support the development and implementation of
5 appropriate education programs for persons receiving treatment
6 for a SUD or in recovery from a SUD and their friends/families that
7 address harm reduction measures.
8 4. Our AMA will advocate for and encourage state and county
9 medical societies to advocate for harm reduction policies that
10 provide civil and criminal immunity for the possession, distribution,
11 and use of “drug paraphernalia” designed for harm reduction from
12 drug use, including but not limited to drug contamination testing
13 and injection drug preparation, use, and disposal supplies.
14 5. Our AMA will implement an education program for patients with
15 substance use disorder and their family/caregivers to increase
16 understanding of the increased risk of adverse outcomes
17 associated with having a substance use disorder and a serious
18 respiratory illness such as COVID-19.
19 6. Our AMA supports efforts to increase access to fentanyl test
20 strips and other drug checking supplies for purposes of harm
21 reduction. (Modify Current HOD Policy)
22

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

Received: 3/31/23

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RELEVANT AMA POLICY

Opioid Mitigation D-95.964

Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle and syringe exchange to state and specialty medical societies.

Citation: BOT Rep. 09, I-19;

Treating Opioid Use Disorder in Hospitals D-95.967

1. Our AMAs Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.
2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.
3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

Citation: Res. 223, A-18;

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22;

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for

OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21;

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.

Citation: Res. 209, A-18; Modified: Res. 520, A-19;

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Citation: CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19;

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions)

throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-23)

Introduced by: Medical Student Section

Subject: Encouraging Collaboration Between Physicians and Industry in AI
(Augmented Intelligence) Development

Referred to: Reference Committee E

1 Whereas, Our American Medical Association supports augmented intelligence (AI) systems
2 that advance the quadruple aim, specifically AMA H-480.939, “Augmented Intelligence in
3 Health Care:”

- 4 (1) To enhance the patient experience of care and outcomes,
 - 5 (2) To improve population health,
 - 6 (3) To reduce overall costs for the healthcare system while increasing value,
 - 7 (4) To support the professional satisfaction of physicians and the healthcare team; and
- 8

9 Whereas, Our AMA seeks to identify opportunities to integrate practicing physicians’
10 perspectives into the development, design, validation, and implementation of health care AI
11 AMA policy H-480.940, “Augmented Intelligence in Health Care”; and
12

13 Whereas, Research from the medical device industry has provided evidence that physicians
14 substantially contribute to medical device innovation, specifically that:

- 15 (1) Physicians contributed to a fifth of medical device patents and generated a great
16 number of citations, demonstrating a substantial physician involvement in medical
17 device innovation¹,
- 18 (2) Physician patents were cited more times by subsequent patents than those without
19 physician involvement, where the number of citation by follow-on inventions indicate
20 the significance of the original innovation¹,
- 21 (3) Physician patents generated more follow-on innovations from a more diverse set of
22 disciplines, emphasizing the broader impact of physician involvement in research¹;
23 and
24

25 Whereas, Research on the implementation of electronic health records (EHRs) has indicated
26 that technology developed with physician involvement is associated with physicians’
27 perceived ease of use and acceptance²; and
28

29 Whereas, Current research on AI has indicated that:

- 30 (1) Physicians assisted by AI models can outperform physicians or AI alone, specifically
31 in diagnosing metastatic breast cancer and diabetic retinopathy^{3, 4},
- 32 (2) Physicians can use interactive AI-based technologies in medical image segmentation
33 and identification, providing evidence that physicians and AI technologies can work
34 together to better fulfill the quadruple aim⁵; and
35

36 Whereas, Our AMA has launched pathways for healthcare innovation, but these pathways
37 are greatly targeted to physicians currently involved in AI, such as Health 2047, a business
38 that connects our AMA to leading experts in AI and machine learning to produce healthcare
39 solutions⁶; and

1 Whereas, Our AMA has supported physician innovation, especially in the field of AI, through
2 the Physician Innovation Network (PIN), an online forum board for entrepreneurs to seek
3 medical specialists to “connect the health care innovation ecosystems to improve the
4 development of emerging healthcare technology solutions”⁷; and
5

6 Whereas, Early analysis of the PIN has identified that early engagement of physicians and
7 respecting a physician’s time and expertise contribute to more meaningful connections
8 between physicians and entrepreneurs⁸; and
9

10 Whereas, The PIN currently experiences limited physician utilization, as evidenced by:

- 11 (1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a
12 small subset of physicians who have already realized early in their careers that they
13 wish to pursue a nontraditional path in medicine and innovation⁹,
- 14 (2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1% of
15 our AMA’s physician membership base¹⁰; and
16

17 Whereas, Our AMA advocates that our organization, national, and medical specialty societies
18 and state medical associations (AMA, H-480.939):

- 19 (1) Leverage medical expertise to ensure clinical validation and assessment of clinical
20 applications of AI systems by practicing physicians,
- 21 (2) Outline a new professional role to aid and guide health care AI systems; therefore be
22 it
23

24 RESOLVED, That our American Medical Association augment the existing Physician
25 Innovation Network (PIN) through the creation of advisors to specifically link physician
26 members of AMA and its associated specialty societies with companies or individuals
27 working on augmented intelligence (AI) research and development, focusing on:

- 28 (1) Expanding recruitment among AMA physician members,
- 29 (2) Advising AMA physician members who are interested in healthcare innovation/AI
30 without knowledge of proper channels to pursue their ideas,
- 31 (3) Increasing outreach from AMA to industry leaders and companies to both further
32 promote the PIN and to understand the needs of specific companies,
- 33 (4) Facilitating communication between companies and physicians with similar interests,
- 34 (5) Matching physicians to projects early in their design and testing stages,
- 35 (6) Decreasing the time and workload spent by individual physicians on finding projects
36 themselves,
- 37 (7) Above all, boosting physician-centered innovation in the field of AI research and
38 development (Directive to Take Action); and be it further
39

40 RESOLVED, That our AMA support selection of PIN advisors through an application process
41 where candidates are screened by PIN leadership for interpersonal skills, problem solving,
42 networking abilities, objective decision making, and familiarity with industry. (New HOD
43 Policy)
44

Fiscal Note: Approximately \$47,000 for identifying, recruiting, promoting, and facilitating
industry-physician relationships through the Physician Innovation Network regarding AI.

Received: 4/3/23

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18;

Augmented Intelligence in Health Care H-480.939

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
 - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
 - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
 - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
 - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
 - a. Identify areas of medical practice where AI systems would advance the quadruple aim;
 - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
 - c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
 - d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-23)

Introduced by: Medical Student Section

Subject: Recognizing the Burden of Rare Disease

Referred to: Reference Committee E

1 Whereas, Rare diseases, also known as orphan diseases, are defined as conditions that affect
2 less than 200,000 individuals in the United States (US), categorized into various overlapping
3 disease classes including but not limited to chromosomal disorders, connective tissue diseases,
4 blood diseases, metabolic disorders, skin diseases, and autoimmune conditions¹⁻³; and

5
6 Whereas, Rare diseases cumulatively affect a significant number of people in the US, estimated
7 to be between 25-30 million individuals⁴; and

8
9 Whereas, Congress passed The Orphan Drug Act (ODA) to incentivize drug companies to
10 develop treatments for rare diseases and rapidly deploy novel agents to target conditions
11 affecting fewer than 200,000 persons in the United States, or conditions for which a drug will not
12 be profitable within 7 years following approval by the FDA⁵⁻⁷; and

13
14 Whereas, Current orphan drug legislation to support biopharmaceutical R&D portfolio diversity,
15 enhance patent exclusivity, and provide distinct FDA designations is not sufficient to promote
16 novel drug development for different rare disease classes as 90% of these patients are without
17 an FDA approved treatment⁸⁻¹⁰; and

18
19 Whereas, The Affordable Care Act does not specifically address orphan drugs coverage, and
20 even when new treatment options such as drug prescriptions or medical devices are available
21 for people with rare diseases, 61% of patients are denied or delayed in accessing treatment due
22 to insurance company pre-approval^{8,11}; and

23
24 Whereas, There are many disparities in rare disease health care including 39% of respondents
25 traveling 60 or more miles for medical care, 17% considering or completing relocation, and 29%
26 being granted access to treatment not approved by FDA^{1,8}; and

27
28 Whereas, The mean health related quality of life scores of those with orphan diseases were the
29 poorest compared to individuals with common chronic diseases, which may be attributed to
30 diagnostic challenges, decreased access to medical information and treatment, and negative
31 psychological impact such as coping with uncertainty¹²; and

32
33 Whereas, In 2019, health care costs associated with orphan diseases may be comparable to
34 heart disease or cancer at \$966 billion, accounting for direct, indirect, and non-medical costs
35 associated with diagnosis and amounting to nearly 50% of the total national bill, despite a vastly
36 lower percentage of rare disease within the population^{10,13,14}; and

37
38 Whereas, The number of documented cases of many rare diseases are only expected to
39 increase given recent advances in genomics and personalized medicine¹⁵; and

1 Whereas, There is a lack of reliable epidemiological data for patients with orphan diseases and
2 insufficient knowledge on the pathophysiology of these conditions among health care providers,
3 leading to inadequate access to information on disease prevalence and treatment outcomes¹⁶;
4 and

5
6 Whereas, A lack of knowledge has made treatment options difficult for patients with orphan
7 diseases to access, contributing to difficulty and delay in diagnosis, as shown by a National
8 Organization for Rare Diseases (NORD) 2019 report that found 28% of individuals diagnosed
9 with a rare disease did not receive a diagnosis for seven years or more and 38% of individuals
10 received a misdiagnosis^{8,17,18}; and

11
12 Whereas, Due to barriers in accessing treatment options, patients with rare diseases have
13 difficulty finding treatment information and patient registries, such as Rare Disease Registries
14 have become a tool for both patients and physicians to be educated on their condition¹⁹; and

15
16 Whereas, Natural history studies and patient registries collecting longitudinal, patient-driven
17 data aided by machine learning help advance our understanding of rare diseases and how they
18 progress over time, facilitating clinical research and the development of novel therapeutics^{8,20};
19 and

20
21 Whereas, Recent automated tracking systems, such as RENEW, are being used to gather new
22 global genomic discoveries onto an accessible database for genome sequencing of patients for
23 improved therapeutic outcomes²¹; and

24
25 Whereas, Incorporation of genomic research as clinical diagnostic tests can increase large
26 scale sequencing projects of structural variants and sharing of data that shortens the time to
27 diagnosis by producing increased cohort sizes for development of personalized therapeutic
28 options²²; and

29
30 Whereas, With future advances in techniques such as genome-wide pooled CRISPR screening
31 and plasmid-based reporter assays, which can shorten time to diagnosis, precision therapeutics
32 could be used as a targeted and efficient approach in orphan disease treatment^{23,24}; and

33
34 Whereas, With only 30% of the genome accounted for in the diagnosis of rare disease there is
35 still 75% of phenotypic variations within the genome unaccounted for, in which future novel gene
36 discovery through sequencing efforts can overcome this diagnostic challenge²⁴; and

37
38 Whereas, AMA policy H-185.963 emphasizes insurance coverage for childhood and congenital
39 diseases, but does not sufficiently include the orphan disease population or specialized genomic
40 research considerations needed for timely diagnosis and treatment; therefore be it

41
42 RESOLVED, That our American Medical Association recognize the under-treatment and under-
43 diagnosis of orphan diseases, the burden of costs to health care systems and affected
44 individuals, and the health disparities among patients with orphan diseases (New HOD Policy);
45 and be it further

46
47 RESOLVED, That our AMA support efforts to increase awareness of patient registries, to
48 improve diagnostic and genetic tests, and to incentivize drug companies to develop novel
49 therapeutics to better understand and treat orphan diseases. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Genetic Information and Insurance Coverage H-185.972

AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.

(2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services.

(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.

(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

Citation: BOT Rep. 15, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed in lieu of Res. 102, A-10; Reaffirmation: A-17; Reaffirmed: BOT Rep. 12, I-21;

Insurance Coverage for Adults with Childhood Diseases H-185.963

Our AMA: (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and

(2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population.

Citation: CMS Rep. 2, I-99; Modified and Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19;

Coverage of Children's Deformities, Disfigurement and Congenital Defects H-185.967

1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed.

2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.

Citation: (Sub. Res. 119, I-97; Reaffirmed, A-03; Reaffirmation A-05; Reaffirmation A-08; Appended: Res. 109, A-13)

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):

- a. Collaborate with the physician community in the development and implementation of patient incentives.
- b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
- c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
- d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
- e. Provide referring and/or primary care physicians with the full record of the service encounter.
- f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
- g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.

2. Our AMA supports the following quality and cost principles for any FIP:

- a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
- b. Provide publicly available information regarding the metrics used to identify, and quality scores

- associated with, lower and higher-cost health care items, services, physicians and facilities.
- c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
 - d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
 - e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
 - f. Provide meaningful transparency of prices and vendors.
 - g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
 - h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
 - i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
 4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
 5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
 6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
 - a. Patient outcomes/the quality of care provided with shopped services;
 - b. Patient utilization of shopped services;
 - c. Patient satisfaction with care for shopped services;
 - d. Patient choice of health care provider;
 - e. Impact on physician administrative burden; and
 - f. Overall/systemic impact on health care costs and care fragmentation.
- Citation: CMS Rep. 2, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-23)

Introduced by: Medical Student Section

Subject: Development and Implementation of Recommendations for Responsible
Media Coverage of Opioid Overdoses

Referred to: Reference Committee E

1 Whereas, The number of opioid-related overdose deaths in the United States has been
2 steadily increasing since 1999, reaching 80,816 deaths in 2021¹⁻³; and
3

4 Whereas, The media has the capacity to condition people's perceptions of and attitudes
5 towards disease severity⁴; and
6

7 Whereas, By selectively including or excluding content, perspectives, and material, media
8 platforms have a powerful capacity to frame issues, shape community attitudes, and impact
9 political decision making⁵; and
10

11 Whereas, Media coverage of the opioid overdose crisis has impacted public attitudes
12 regarding the crisis and the subsequent response⁵⁻⁷; and
13

14 Whereas, The *Herald Sun* newspaper in Australia effectively put heroin at the forefront of the
15 public agenda by consistently highlighting heroin-related overdose deaths in the 1990s⁵; and
16

17 Whereas, In the United States from 2008-2013, the news media used an increasing amount
18 of stigmatizing language, such as referring to victims of addiction as "substance abusers" or
19 "addicts" (appeared in 49% of stories) in lieu of less stigmatizing substitutes such as "person
20 with a substance use disorder" (appeared in 2% of stories), potentially leading to increased
21 stigma regarding opioid addiction among the American public⁶; and
22

23 Whereas, In the United States from 1998-2012, coverage of the opioid epidemic focused on
24 criminal justice solutions for the opioid epidemic; this coverage shifted to increasingly
25 emphasize treatment, harm reduction, and prevention from 2013-2017, largely mirroring
26 increased public acceptance that the War on Drugs had failed⁷; and
27

28 Whereas, Despite increased coverage of the opioid epidemic in the United States occurring
29 through the framework of prevention and treatment from 2013-2017, many evidence-based
30 solutions were rarely mentioned, including the use of medication for treatment (9% of
31 stories), syringe service programs (5% of stories), and safe injection sites (2% of stories)⁷;
32 and
33

34 Whereas, The lack of mention of these evidence-based interventions in the news media is
35 correlated with reduced public acceptance of these approaches for treatment of the opioid
36 epidemic⁷⁻⁹; and

1 Whereas, The stigma surrounding opioid addiction and strategies for harm reduction have
2 significantly hindered the public health response to the opioid epidemic in the United States¹⁰;
3 and
4

5 Whereas, Increased stigma associated with media coverage of the opioid epidemic adversely
6 impacts the ability of patients to seek and receive treatment for opioid addiction, as 25% of
7 individuals report negative impacts on their job or fear of a negative opinion of community
8 members as reasons for not seeking treatment¹¹; and
9

10 Whereas, News media framing of the opioid epidemic in the context of race has contributed
11 to the differentiation of “white from black (and brown) suffering, white from black culpability,
12 and white from black deservingness” in the public discourse¹²; and
13

14 Whereas, Coded language used by the media can also contribute to the framing of issues,
15 for example by establishing “urban” as code for Black or Latino and “suburban”/“rural” as
16 code for White, effectively creating perceived separate spaces for white and Black drug
17 users¹²; and
18

19 Whereas, This difference in framing leads to a system where Black and Brown people who
20 use drugs are more likely to be incarcerated and less likely to be offered access to healthcare
21 providers, addiction treatment, and tools to prevent overdose and infection¹²; and
22

23 Whereas, News media framing of White victims of the opioid epidemic as innocent and their
24 deaths as shocking or out of the ordinary contrasts with persistent framing of the opioid
25 epidemic in Black or Brown communities as normal, contributing to increased stigma¹³; and
26

27 Whereas, Stigmatization and marginalization of victims of opioid addiction are associated
28 with greater support for punitive policies instead of investment in prevention and treatment
29 programs¹⁴; and
30

31 Whereas, Ecological studies have shown a significant tendency for increases in fatal
32 overdoses to follow increased media coverage of opioid-related deaths¹⁵; and
33

34 Whereas, Our American Medical Association supports the development of standards for
35 media coverage of mass shootings to help address the gun violence public health crisis in
36 Policy H-145.971, showing that the precedent exists for the AMA to encourage more
37 thoughtful public engagement with health-related issues; therefore be it
38

39 RESOLVED, That our American Medical Association encourage the Centers for Disease
40 Control and Prevention, in collaboration with other public and private organizations, to
41 develop recommendations or best practices for media coverage and portrayal of opioid drug
42 overdoses. (New HOD Policy)
43

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

Received: 4/3/23

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RELEVANT AMA POLICY

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Citation: Res. 212, I-18; Modified: Res. 934, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-23)

Introduced by: Medical Student Section

Subject: Addressing Medical Misinformation Online

Referred to: Reference Committee E

- 1 Whereas, Medical misinformation is information contrary to the consensus of the scientific
2 community that may or may not be intended to mislead, while medical disinformation is
3 misinformation that is deliberately spread with intent to mislead¹⁻³; and
4
- 5 Whereas, Medical misinformation is spread by many different sources online, such as online
6 forums, advertisements, user comments on news and retail sites, social media, search
7 engines, digital magazines, and products sold by online retailers^{1,3,4,5}; and
8
- 9 Whereas, Medical misinformation has a large impact on a wide variety of healthcare topics
10 including smoking, statin use, use of unproven treatments, harassment of health workers,
11 and vaccine hesitancy^{5,6}; and
12
- 13 Whereas, It was found that misinformation propagated significantly farther and faster online
14 than did accurate information^{5,7,8}; and
15
- 16 Whereas, Misinformation about the Zika virus was three times more likely to be shared than
17 were verified stories as seen on multiple social media sites, with half of the top-10 news
18 stories regarding Zika thought to be misinformation^{7,8}; and
19
- 20 Whereas, More than half of the United States population used the internet as their primary
21 source for health information in 2018, indicating a reliance on websites for health
22 information⁹; and
23
- 24 Whereas, Research has shown that exposure to just five online misinformation posts about
25 the COVID-19 vaccine were sufficient to make respondents less likely to want a COVID-19
26 vaccine^{5,10}; and
27
- 28 Whereas, Search engine algorithms provide results based on the user's search history and
29 usage of suggested sites or videos, meaning that if one clicks on a site or video promoting
30 medical misinformation, they will have more misinformation sites or videos promoted to them
31 over accurate information^{5,11}; and
32
- 33 Whereas, The likelihood that a person will view a particular website and then trust in that
34 website are influenced by its order of appearance on major search engines^{12,13}; and
35
- 36 Whereas, Search engines often fail to ensure that the search results provided are credible or
37 trustworthy¹³; and

1 Whereas, Search engine algorithms can lead a single (potentially unintentional) click on a
2 medical misinformation link to result in an echo chamber effect where personalized results
3 are heavily in favor of medical misinformation¹³; and
4

5 Whereas, Sites or product owners can pay to be promoted on the front page of a search
6 engine and therefore increase their influence, creating a potential source of misinformation if
7 not moderated properly¹²; and
8

9 Whereas, Search engines for online retailer sites such as Amazon are biased in favor of
10 misinformative products such as anti-vaccination books, ranking them higher in search
11 results¹³; and
12

13 Whereas, Inadequate moderation and verification of user testimonials on both WebMD and
14 online retailers like Amazon have promoted the idea of using apricot seeds as a cancer
15 treatment, leading to a 4.60 out of 5 rating for effectiveness on WebMD despite the site's own
16 description of apricot seeds as "likely unsafe"¹; and
17

18 Whereas, Three measures for quality of information showed that the websites from the first
19 10 pages of Google searches on COVID-19 were lacking in quality, with only 52.7% of
20 prevention-focused websites mentioning physical distancing, and the number of sites
21 suggesting treatment via oxygen, ventilation and fluids was equal to the number of sites
22 suggesting hydroxychloroquine¹⁴; and
23

24 Whereas, Our AMA endorses efforts to combat medical misinformation in Policy D-440.915,
25 but this policy is currently limited to online medical misinformation from social media, without
26 any regard for any other potential online vectors such as search engines, online retailers, or
27 any other type of website online; therefore be it
28

29 RESOLVED, That our American Medical Association policy D-440.915 be amended by
30 addition and deletion to read as follows:
31

32 **Medical and Public Health Misinformation in the ~~Age of Social~~**
33 **Media Online D-440.915**

34 Our AMA:

- 35 (1) encourages social media companies and organizations, search
36 engine companies, online retail companies, online healthcare
37 companies, and other entities owning websites to further strengthen
38 their content moderation policies related to medical and public health
39 misinformation, including, but not limited to enhanced content
40 monitoring, augmentation of recommendation engines focused on false
41 information, and stronger integration of verified health information;
42 (2) encourages social media companies and organizations, search
43 engine companies, online retail companies, online healthcare
44 companies, and other entities owning websites to recognize the spread
45 of medical and public health misinformation over dissemination
46 networks and collaborate with relevant stakeholders to address this
47 problem as appropriate, including but not limited to altering underlying
48 network dynamics or redesigning platform algorithms;

- 1 (3) will continue to support the dissemination of accurate medical and
- 2 public health information by public health organizations and health
- 3 policy experts; and
- 4 (4) will work with public health agencies in an effort to establish
- 5 relationships with journalists and news agencies to enhance the public
- 6 reach in disseminating accurate medical and public health information.
- 7

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

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RELEVANT AMA POLICY

Medical and Public Health Misinformation in the Age of Social Media D-440.915

Our AMA: (1) encourages social media companies and organizations 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 and organizations 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; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will 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.

Citation: Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-23)

Introduced by: Medical Student Section

Subject: Comparative Effectiveness Research

Referred to: Reference Committee E

1 Whereas, Pharmaceutical companies submit investigational new drug (IND) applications to seek
2 Food and Drug Administration (FDA) approval for new medications and supplemental new drug
3 (NDA) applications to seek FDA approval for additional clinical indications for a previously
4 approved medication^{1,2}; and

5
6 Whereas, Widespread off-label use of many medications by physicians indicates that
7 pharmaceutical companies do not submit NDAs at a rate that keeps pace with emerging clinical
8 practice²; and

9
10 Whereas, A study of 197 new drugs that were approved by the FDA and became available as
11 generics between 1997 and 2020 demonstrated that new FDA indications for additional clinical
12 conditions were added for 64 drugs (32%), which occurred almost exclusively while they were
13 still patented even when off-label uses for those drugs emerged afterward, suggesting that
14 generic availability disincentivizes pharmaceutical company trials to seek new indications³; and

15
16 Whereas, While off-label use of drugs by physicians is common and often beneficial for patient
17 access to treatment, the lack of adequate clinical trials, such as those conducted by
18 pharmaceutical companies, to seek new FDA indications when off-label uses emerge limits the
19 evidence basis for their use and importantly, reimbursement by insurance plans⁴; and

20
21 Whereas, Pharmaceutical companies patent, run clinical trials for, and profit from INDs that are
22 structurally, functionally, and therapeutically similar to existing generic medications or natural
23 products that are widely available in other formulations^{5,6}; and

24
25 Whereas, As a natural product, melatonin is not patentable and can be purchased over the
26 counter as a dietary supplement for 10 cents a tablet⁷; and

27
28 Whereas, Ramelteon (brand name Rozerem) is a melatonin derivative which aims to improve
29 sleep by stimulating the melatonin receptor, thus employing the same mechanism of action as
30 the naturally occurring substance melatonin^{8,9}; and

31
32 Whereas, As a non-natural product, Ramelteon was able to be patented, leading to a cost of
33 approximately 10 dollars per pill, which is 100x the cost of a melatonin dietary supplement pill,
34 despite lack of testing to show a difference in efficacy between Ramelteon and melatonin⁹; and

35
36 Whereas, As another example, ketamine, an NMDA receptor antagonist approved by the FDA
37 in 1970 as an anesthetic, demonstrated efficacy as an off-label antidepressant in the early
38 2000s^{10,11}; and

1 Whereas, Despite ketamine's efficacy as an off-label antidepressant and its wide availability and
2 low cost in generic oral and IV formulations, no pharmaceutical company has attempted to add
3 depression as an FDA indication for oral or IV ketamine, even though FDA indications are often
4 tied to insurance reimbursement¹²; and
5

6 Whereas, Experts attribute the lack of a ketamine FDA approval for depression to its 2002
7 patent expiration, which then allowed the production of generic ketamine, reducing potential
8 profit, and removing the incentive for pharmaceutical companies to conduct expensive clinical
9 trials to add depression as an indication for oral or IV ketamine¹²; and
10

11 Whereas, While adding depression as an indication for oral or IV ketamine is not necessary, as
12 these available generic formulations can still be prescribed for depression off-label, Johnson &
13 Johnson proceeded to conduct clinical trials for an IND application for a similar compound that
14 could be patented and sold for higher profits, which resulted in the 2019 FDA approval of
15 esketamine (brand name Spravato) nasal spray¹³; and
16

17 Whereas, A cost-effectiveness study of esketamine concluded that its price would need to
18 decrease by nearly half in order to be cost-effective for treatment-resistant depression in the
19 US¹⁴; and
20

21 Whereas, Many of the esketamine clinical trials analyzed for its FDA approval only compared it
22 to placebo and not to existing formulations of the structurally similar oral or IV ketamine, and
23 several studies suggest that differences in antidepressant efficacy between esketamine and
24 ketamine may be negligible or that ketamine may even be superior to esketamine¹⁵; and
25

26 Whereas, Ketamine remains inadequately studied and does not have an FDA indication as an
27 antidepressant, despite its wide availability as a generic, relatively low cost (especially
28 compared to the patented esketamine), and potential clinical benefit to millions of Americans
29 suffering from treatment-resistant depression^{12,16,17}; and
30

31 Whereas, The AMA "supports programs whose purpose is to contain the rising costs of
32 prescription drugs" (H-110.997); and
33

34 Whereas, The AMA supports "autonomous clinical decision-making authority of a physician and
35 that a physician may lawfully use an FDA approved drug product or medical device for an off-
36 label indication when such use is based upon sound scientific evidence" (H-120.988); and
37

38 Whereas, Proper comparisons in clinical trials can give physicians the scientific evidence
39 needed to provide the best care for their patients, while simultaneously containing the cost of
40 prescription drugs by avoiding prescribing drugs that have significantly greater cost but show no
41 additional clinical benefit; therefore be it
42

43 RESOLVED, That our American Medical Association study the feasibility of including
44 comparative effectiveness studies in various FDA drug regulatory processes, including
45 comparisons with existing standard of care, available generics and biosimilars, and drugs
46 commonly used off-label and over-the-counter (Directive to Take Action); and be it further
47

48 RESOLVED, That our AMA ask the National Institutes of Health to support and fund
49 comparative effectiveness research for approved drugs, including comparisons with existing
50 standard of care, available generics and biosimilars, and drugs commonly used off-label and
51 over-the-counter. (Directive to Take Action)

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

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RELEVANT AMA POLICY

E7.2.3 Patents & Dissemination of Research Products

A patent grants the holder the right, for a limited time, to prevent others from commercializing his or her inventions. By requiring full disclosure of the invention, and thus enabling another trained in the art to replicate it, the patent system protects the holder's discovery, yet also fosters information sharing. Patenting is also thought to encourage private investment into research.

With respect to genetic research, patenting raises unique questions. Arguments have been made that the patenting of human genetic material sets a troubling precedent for the ownership or commodification of human life. However, DNA sequences are not tantamount to human life and it is unclear where and whether qualities uniquely human are found in genetic material. Moreover, while genetic research holds great potential for developing new medical therapies it remains unclear what role patenting will play in ensuring such development.

Physicians who develop medical innovations may ethically patent their discoveries or products but should uphold the following guidelines:

- (a) Not use patents (or other means, such as trade secrets or confidentiality agreements) to limit the availability of medical innovations. Patent protection should not hinder the goal of achieving better medical treatments and technologies.

(b) Not allow patents to languish. Physicians who hold patents should negotiate and structure licensing agreements in such a way as to encourage the development of better medical technology.

(c) For patents on genetic materials recognize that:

(i) patents on processes, e.g. to isolate and purify gene sequences, are ethically preferable to patents on the substances themselves;

(ii) patents on purified proteins (substance patents) are ethically preferable to patents on genes or DNA sequences.

Descriptions for (substance) patents on proteins, genes, or genetic sequences should be carefully constructed to ensure that the patent holder does not limit the use of a naturally occurring form of the substance in question.

Issued: 2016

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22;

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20;

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.

2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.

3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.

4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

Citation: Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22;

Generic Drugs H-125.984

Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.

(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.

(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.

(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.

(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.

(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).

(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.

Citation: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10; Reaffirmed in lieu of Res. 224, I-14; Reaffirmed in lieu of: Res. 922, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-23)

Introduced by: Medical Student Section

Subject: Regulation of Phthalates in Adult Personal Sexual Products

Referred to: Reference Committee E

1 Whereas, The American Academy of Pediatrics characterizes phthalates as ubiquitous
2 contaminants in food, indoor air, soils, and sediments¹; and
3

4 Whereas, Typical routes of exposure include transfer from hands to mouth, breathing in
5 phthalates in the air, undergoing medical procedures that use devices or equipment
6 containing di(2-ethylhexyl) phthalate (DEHP), and consuming food containing phthalates as a
7 result of packaging or processing²; and
8

9 Whereas, In animal studies, phthalates have been shown to cause fetal death,
10 malformations, and reproductive toxicity, and in one systematic review, prenatal phthalate
11 exposure was associated with neurodevelopmental outcomes, including lower IQ and
12 problems with attention and hyperactivity³; and
13

14 Whereas, It is important to understand the impact of phthalates on health as number of
15 animal studies have primarily shown phthalate exposure can cause harmful reproductive and
16 developmental effects⁴; and
17

18 Whereas, Human studies have been observational to link phthalate metabolites in urine to a
19 variety of health outcomes such as an increased risk of type 2 diabetes in some populations
20 of women, delayed puberty in women, and relationships of decreased sperm with increased
21 urinary phthalate concentration⁵⁻⁷; and
22

23 Whereas, Currently, eight phthalates are banned from children's toys and childcare items by
24 the United States Consumer Product Safety Commission (CPSC) due to harmful health
25 effects, including on reproductive development^{10,11}; and
26

27 Whereas, Although the data is unclear on the adverse effects of exposure of skin and
28 mucous membranes to DEHP, there are associations between di(2-ethylhexyl) phthalate
29 (DEHP) and adverse health outcomes¹³; and
30

31 Whereas, The FDA has recognized the adverse health effects of phthalates in medical
32 devices in indwelling devices and transfusion devices, and has also advised against the use
33 of phthalates in pharmaceuticals regulated by the Center for Drug Evaluation and Research
34 (CDER)¹⁵; and
35

36 Whereas, The United States Consumer Product Safety Commission (US CPSC) published a
37 risk assessment for exposure to phthalates and phthalate alternatives in 2014¹⁶; and

1 Whereas, There is little data pertaining to how widespread the negative outcomes for
2 phthalate exposure are in humans and there is also a lack of human studies about phthalate
3 exposure from sex toys specifically; and
4

5 Whereas, Given the evidence that phthalates have a possibility of having a negative impact
6 on human health, specifically in the case of DEHP, it would be appropriate for our AMA to
7 take a stance on the use of these compounds in all consumer products, sexual or otherwise;
8 and
9

10 Whereas, Our American Medical Association has current policy (H-135.945) that addresses
11 the health risks of DEHP in medical devices; therefore be it
12

13 RESOLVED, That our American Medical Association amend policy H-135.945 by addition
14 and deletion to read as follows:
15

16 Encouraging Alternatives to PVC/Phthalate ~~DEHP~~ Products in Health H-135.945
17

18 Our AMA:

19 (1) encourages hospitals and physicians to reduce and phase out polyvinyl
20 chloride (PVC) ~~medical device~~ products, especially those containing phthalates
21 such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-
22 effective, alternative products where available; ~~and~~

23 (2) urges expanded manufacturer development of safe, cost-effective alternative
24 products to PVC ~~medical device~~ products, especially those containing phthalates
25 such as DEHP;

26 (3) encourages the U.S. Consumer Product Safety Commission to conduct a risk
27 assessment of adult personal sexual products as a source of phthalates; and

28 (4) supports consumer education about the potential for exposure to toxic
29 substances in adult personal sexual products. (Modify Current HOD Policy)
30

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

Received: 4/3/23

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11. "CPSC Prohibits Certain Phthalates in Children's Toys and Child Care Products." U.S. Consumer Product Safety Commission, United States Government, 8 Nov. 2017, www.cpsc.gov/content/cpsc-prohibits-certain-phthalates-in-children%E2%80%99s-toys-and-child-care-products.
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RELEVANT AMA POLICY

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.

Citation: BOT Action in response to referred for decision Res. 502, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-23)

Introduced by: American Academy of Physical Medicine & Rehabilitation; American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Wheelchairs on Airplanes

Referred to: Reference Committee E

1 Whereas, More than five million Americans use a wheelchair for mobility¹; and
2
3 Whereas, The Americans with Disability Act requires all modes of public transportation, except
4 for airlines, to have the capability for wheelchair users to stay in their wheelchairs during
5 transport and be able to enter and exit boats, buses, or trains; and
6
7 Whereas, Currently, patients who are unable to walk due to a medical illness or condition and
8 who use a wheelchair for mobility must transfer or be transferred by airline staff to a special
9 airline chair to enter an aircraft and then must transfer or be transferred by airline personnel to a
10 seat in the aircraft, risking injury due to incorrect transfer technique by inexperienced personnel,
11 such as hitting the armrests; and
12
13 Whereas, Patients with significant musculoskeletal weakness or spinal or other deformity have
14 wheelchairs with specialized seating to support their bodies in comfortable and safe positions,
15 but airplane seats have no special support, leaving the patients unstable in their seats and at
16 risk of injury during turbulence or unusual landings; and
17
18 Whereas, A feasibility study was commissioned by Congress through the Federal Aviation
19 Administration (FAA) Reauthorization Act of 2018 and the results “did not show any issues in
20 this preliminary assessment that seem likely to present design and engineering challenges so
21 formidable that they call into question the technical feasibility of an in-cabin wheelchair
22 securement system and the value of exploring the concept further,”²; and
23
24 Whereas, New wheelchair securement systems have been tested that exceed the FAA safety
25 requirement of 16 G deceleration forces for airplane seats^{2,3}; and
26
27 Whereas, Patients who use wheelchairs as their only means of mobility who have traveled on
28 airplanes have experienced lost and broken wheelchairs, leaving them at the airport with no
29 means of mobility and subsequent avoidance of air travel altogether⁴; therefore be it
30
31 RESOLVED, That our American Medical Association encourage Congress and the FAA to
32 change the rules for commercial flights so that modifications must be made to planes to allow
33 passengers whose only means of mobility is the wheelchair to stay in their personal wheelchairs
34 during flight and while entering and exiting the plane. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Academy of Addiction Psychiatry, American Society of Addiction Psychiatry

Subject: Substance Use History is Medical History

Referred to: Reference Committee E

- 1 Whereas, Addiction is a chronic brain disease¹ and is the most severe form of substance use
2 disorder, a chronic medical illness with potential for both recurrence and remission²; and
3
4 Whereas, Substance use disorder has been recognized by our American Medical Association
5 as a treatable disease in policy H-95.922, "*Substance Use and Substance Use Disorders*"; and
6
7 Whereas, 20.1 million Americans have a substance use disorder and only 6.9% receive
8 treatment³ and 1 in 7 people in the United States will develop a substance use disorder over the
9 course of their lifetime²; and
10
11 Whereas, Substance use disorder has historically been viewed as a moral failing and social
12 problem rather than a chronic medical illness, and treatment of substance use disorders has
13 been siloed from mainstream healthcare and patients with substance use disorders have been
14 subjected to discrimination and stigma by the healthcare system and healthcare providers; and
15
16 Whereas, Medical schools teach substance use history as part of a patient's social history and
17 not the past medical history; and
18
19 Whereas, Electronic health record software is designed to capture substance use history in the
20 social history section and not in the past medical history section of clinical documentation; and
21
22 Whereas, Negative attitudes among healthcare professionals regarding patients with substance
23 use disorders are linked with reduced empathy and engagement with patients, reduced delivery
24 of evidence-based treatment services and poorer patient outcomes⁴; and
25
26 Whereas, Existing AMA policies D-95.981, "*Improving Medical Practice and Patient/Family*
27 *Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction*" and H-
28 95.922 call for our AMA to take a positive stance as the leader in matters concerning substance
29 use disorders, including addiction and to assist in reducing the stigma associated with
30 substance use; and
31
32 Whereas, Drugs and alcohol are biologically active substances that upon ingestion alter one's
33 physiological functioning and have a direct impact on health; and

1 Whereas, History-gathering about substance use and the chronic treatable medical illness of
2 substance use disorder as part of a patient’s past medical history would destigmatize substance
3 use and would promote the provision of evidence-based care; therefore be it
4

5 RESOLVED, That our American Medical Association support that substance use history is part
6 of the medical history and should be documented in the medical history section of a patient’s
7 health record (New HOD Policy); and be it further
8

9 RESOLVED, That our AMA support that all medical schools train medical students to take a
10 thorough and nonjudgmental substance use history as part of a patient’s medical history (New
11 HOD Policy); and be it further
12

13 RESOLVED, That our AMA work with relevant stakeholders to advocate for electronic health
14 record vendors to modify their software to allow for substance use history to be documented in
15 the past medical history and to move the substance use history from the social history section of
16 electronic health record technology. (Directive to Take Action)

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

Received: 5/2/23

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4. van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence* 2013;131:23– 35

RELEVANT AMA POLICY

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Citation: Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Substance Use and Substance Use Disorders H-95.922

Our AMA:

(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships

with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20;

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:

a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;

b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;

c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;

d. will consult with relevant agencies on potential strategies to actively involve physicians in being "a part of the solution" to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and

e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:

a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;

b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and

c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Citation: CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 09, I-19; Reaffirmed: BOT Rep. 14, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Society of Addiction Medicine

Subject: Adolescent Hallucinogen-Assisted Therapy Policy

Referred to: Reference Committee E

1 Whereas, Hallucinogens including but not limited to psilocybin and MDMA (3,4-methylenedioxy-
2 methamphetamine) are designated as drugs with no currently accepted medical use¹; and
3
4 Whereas, There are emerging research findings demonstrating clinically significant reduction of
5 refractory depression and post-traumatic stress disorder (PTSD), respectively, in adult patients²;
6 and
7
8 Whereas, Additional research is needed to better understand the benefits and harms of
9 psychedelic therapy in pediatric patients; and
10
11 Whereas, The majority of the states have pending legislation or ballot initiatives to decriminalize
12 psychedelics and licensure would be provided to prescribe psychedelics or to allow for
13 psychedelic-assisted psychotherapy³; and
14
15 Whereas, The prevalence of adolescent depression continues to increase and adolescent
16 suicide is the second leading cause of death among people aged 15 to 24, there is a need for
17 more investment in adolescent mental health research, interventions, and treatments⁴; and
18
19 Whereas, Clinical treatments should be determined by scientific evidence in accordance with
20 applicable regulatory standards and not by ballot initiatives or popular opinion; therefore be it
21
22 RESOLVED, That our American Medical Association advocate against the use of psychedelics
23 to treat any psychiatric disorder except within the context of approved investigational studies
24 (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA advocate for continued research and therapeutic discovery into
27 psychedelic agents with the same scientific integrity and regulatory standards applied to other
28 promising therapies in medicine. (Directive to Take Action)

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

Received: 5/2/23

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2. Siegel, J.S., Daily, J.E., Perry, D.A., Nicol, G.E. (2023). Psychedelic Drug Legislative Reform and Legalization in the US. *JAMA Psychiatry*, 80(1):77-83.
3. Zagorski, N. (2020). Psychedelics for Psychiatric Disorders: More Research Needed. *Psychiatric News*, published Online 13 Apr.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-23)

Introduced by: Mississippi

Subject: Regulate Kratom and Ban Over-The-Counter Sales

Referred to: Reference Committee E

1 Whereas, Kratom is a herbal supplement derived from a tropical tree, *Mitragyna speciosa*, that
2 has been used for centuries in Southeast Asia to alleviate pain, fatigue, and enhance mood; and
3

4 Whereas, Kratom has been marketed in the US as an over-the-counter supplement for similar
5 uses, but there is limited scientific evidence to support its safety and efficacy, and concerns
6 have been raised about its potential for addiction, abuse, and adverse effects, including
7 seizures, liver damage, and death; and
8

9 Whereas, Kratom is not currently regulated by the Food and Drug Administration (FDA) and has
10 not undergone clinical trials to determine its safety and effectiveness; and
11

12 Whereas, The American Medical Association recognizes the potential for kratom to be used as
13 an alternative treatment for opioid addiction, but also acknowledges the need for further
14 research to determine its safety and effectiveness; and
15

16 Whereas, The AMA believes that the regulation of kratom is necessary to ensure the safety and
17 well-being of patients and the general public; therefore be it
18

19 RESOLVED, That our American Medical Association recommend the following:
20

- 21 1. Kratom should be regulated by the FDA, and its safety and efficacy should be
22 determined through clinical trials before it can be marketed or prescribed as a treatment
23 for any condition.
- 24 2. Over-the-counter sales of kratom should be banned, and kratom should be available
25 only by prescription from a licensed healthcare provider if it is deemed to have a
26 medicinal use after proper research.
- 27 3. Individuals who are currently using kratom for pain management or other conditions
28 should have access to appropriate medical care to manage their conditions and
29 withdrawal symptoms, if needed.
- 30 4. Criminalization of kratom use should not be the intent of this resolution, and individuals
31 who are using kratom for legitimate medical reasons should not be subject to criminal
32 penalties although if it is banned, this does not exclude criminalization of drug trafficking.
- 33 5. The Drug Enforcement Administration should conduct a comprehensive review of the
34 potential for kratom abuse and dependence and consider appropriate scheduling under
35 the Controlled Substances Act. A schedule 3 would make it unavailable over the counter
36 but avoid criminal penalties.
- 37 6. Research funding should be made available to study the potential therapeutic uses and
38 risks of kratom, and to develop evidence-based guidelines for its safe use.

- 1 7. Education and public awareness campaigns should be launched to inform healthcare
- 2 providers, patients, and the general public about the potential risks and benefits of
- 3 kratom and the need for caution in its use. (New HOD Policy)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-23)

Introduced by: Senior Physicians Section

Subject: Fasting is Not Required for Lipid Analysis

Referred to: Reference Committee E

- 1 Whereas, Our American Medical Association has recognized that cardiovascular morbidity and
2 mortality is an urgent public health concern; and
3
4 Whereas, Lipids analysis is one of the most ordered lab tests; and
5
6 Whereas, All adult patients should have a lipid analysis for assessment of their cardiovascular
7 risk; and
8
9 Whereas, Patients are usually asked to fast for eight hours for lipid analysis; and
10
11 Whereas, Studies show that lipids and lipoproteins change only minimally in response to normal
12 food intake¹; and
13
14 Whereas, There is no scientific evidence that fasting is superior to non-fasting in evaluating
15 cardiovascular risk from lipid analysis; and
16
17 Whereas, All adult patients with diabetes should have a lipid analysis and fasting may increase
18 risk of hypoglycemia, a risk minimized by non-fasting in patients with diabetes; and
19
20 Whereas, Guidelines from relevant medical societies in the United States, United Kingdom,
21 Europe, and elsewhere endorse non-fasting lipid profiles; and
22
23 Whereas, Pediatrics does not require fasting blood for lipid analysis in children and adolescents
24 since the sample could be drawn at the same time as their physician visit; and
25
26 Whereas, Not fasting would simplify timing of blood draws while avoiding the inconvenience of
27 early morning sampling, additional trips to the lab and a second copay; therefore be it
28
29 RESOLVED, That our American Medical Association develop educational programs affirming
30 that fasting is not required for lipid analysis. (Directive to Take Action)

Fiscal Note: Approximately \$50k for the development of CME-accredited interactive e-learning including staff costs and external vendor contracting.

Received: 4/26/23

REFERENCES

1. Nordestgaard, B. G., Langsted, A., Mora, S., Kolovou, G., Baum, H., Bruckert, E., ... & Langlois, M. (2016). Fasting is not routinely required for determination of a lipid profile: clinical and laboratory implications including flagging at desirable concentration cut-points—a joint consensus statement from the European Atherosclerosis Society and European Federation of Clinical Chemistry and Laboratory Medicine. *European heart journal*, 37(25), 1944-1958.

RELEVANT AMA POLICY

Prevention of Coronary Artery Disease H-425.990

The AMA believes that (1) total serum cholesterol should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease.

Citation: Res. 165, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

Point of Care Availability for Blood Glucose Testing D-260.994

Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing.

Citation: (Res. 727, A-14)

Reference Committee F

BOT Report(s)

- 01 Annual Report
- 04 AMA 2024 Dues
- 13 Delegate Apportionment and Pending Members
- 18 Making AMA Meetings Accessible
- 20 Surveillance Management System for Organized Medicine Policies and Reports

HOD Comm on Compensation of the Officers

- 01 Report of the HOD Committee on the Compensation of the Officers

Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies

Resolution(s)

- 601 Solicitation using the AMA Brand
- 602 Supporting the Use of Gender-Neutral Language
- 603 Environmental Sustainability of AMA National Meetings
- 604 Speakers Task Force to Review and Modernize the Resolution Process
- 605 Equity and Justice Initiatives for International Medical Graduates

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-23

Subject: Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

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- 1 The Consolidated Financial Statements for the years ended December 31, 2022 and 2021 and the
 - 2 Independent Auditor's report have been included in a separate booklet, titled "2022 Annual
 - 3 Report." This booklet is included in the Handbook mailing to members of the House of Delegates
 - 4 and will be discussed at the Reference Committee F hearing.



2022 ANNUAL REPORT

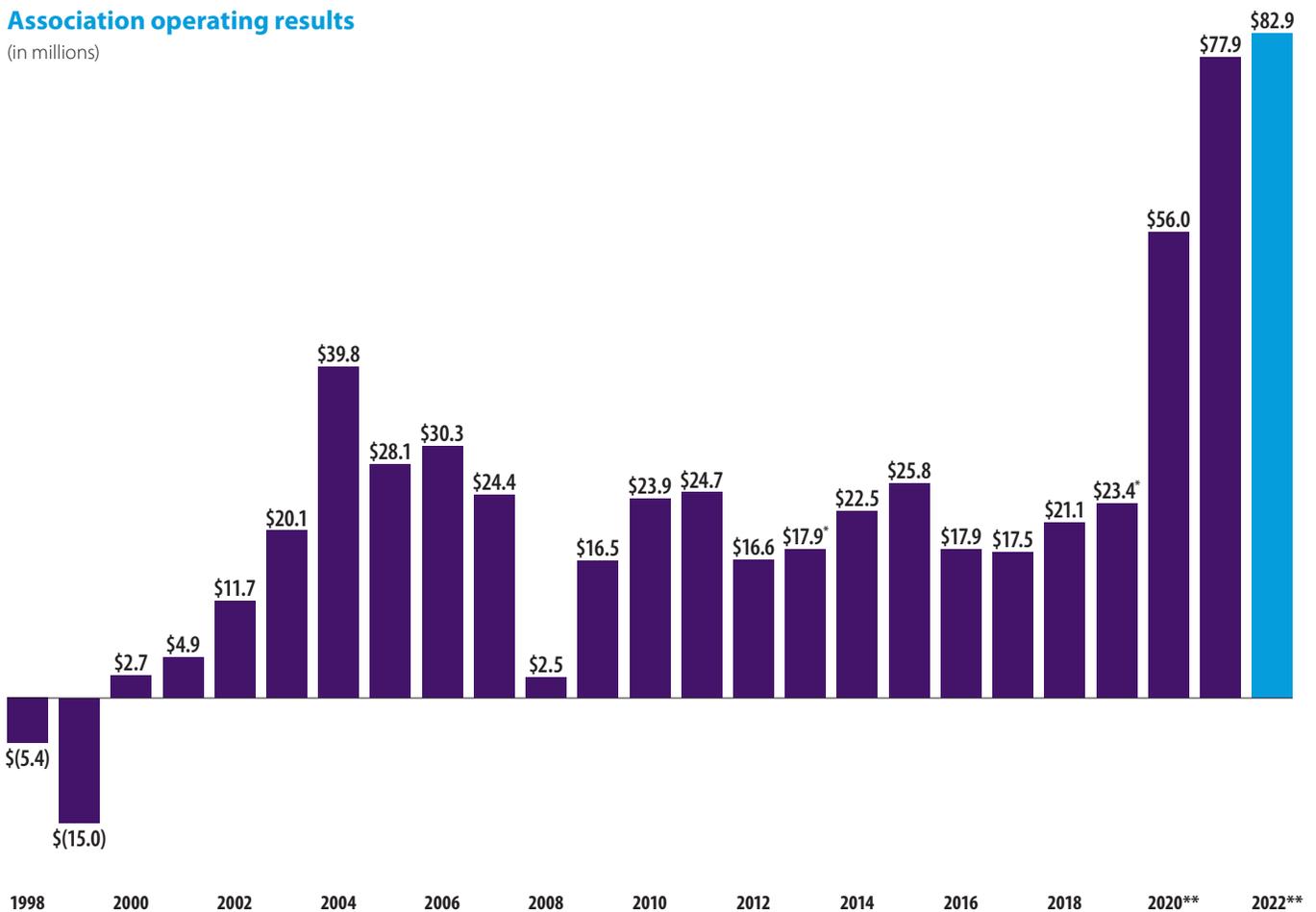
Fighting for physicians

Financial highlights

(Dollars in millions)	2022	2021
Revenues	\$ 493.4	\$ 459.7
Cost of products sold and selling expense	30.6	25.9
General and administrative expenses	375.5	352.3
Operating results	82.9	77.9
Non-operating items	(117.9)	79.5
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	29.4	5.6
Change in unrestricted equity	(5.6)	163.0
Change in donor restricted equity	0.1	(0.1)
Change in association equity	(5.5)	162.9
Association equity at year-end	\$ 889.4	\$ 894.9
Employees at year-end	1,267	1,206

Association operating results

(in millions)



* Pro forma operating results: 1) 2013 excludes \$33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes \$36.2 million noncash pension termination expense reclassification from non-operating results.

** 2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings are temporary in nature.

Letter to stakeholders

It's been more than three years since the pandemic took hold of our nation and placed unrelenting pressure upon America's physicians and patients. While the number of deaths slowed and the cases trended downward through much of 2022, the pandemic underscored the urgent need to better support physicians who take care of this nation—and fix what's broken in health care. And the AMA answered.

The AMA met the challenge by introducing its Recovery Plan for America's Physicians. The strategy laid out specific actions needed to strengthen our nation's physician workforce, improve access to necessary care and rebuild our health system to more effectively respond to the next health crisis—whatever it may be.

In its first year the Recovery Plan delivered promising results, as AMA advocacy helped secure significant wins that locked in important telehealth expansions and protected physicians by limiting Medicare payment cuts. But this progress is not nearly enough. Much more is needed in 2023 and beyond to help physicians and their practices recover from the trauma of the pandemic and to help eliminate the pain points that continue to threaten patient care and drive physician dissatisfaction and burnout.

In a year that marked the organization's 175th anniversary, the AMA in 2022 continued to fight relentlessly—through the courts, in the halls of Congress and in state legislatures across the country—on behalf of physicians and patients. We are proud that ours was among the nation's leading nonpartisan voices for science and vaccine efficacy, for advancing health equity, and in cutting through the fog of medical disinformation and misinformation.

And we are equally proud that our voice once again set new standards for physician engagement across multimedia platforms, from content offered on our ever-expanding AMA Ed Hub™ digital education platform to record numbers of media impressions and unique visitors to our flagship website, growth that surpassed the record-high numbers from the pandemic's first year.

Other aspects fundamental to the AMA's mission flourished as well. The AMA released a special edition of its *Code of Medical Ethics*, and the *Journal of the American Medical Association*, under the direction of new Editor-in-Chief Kirsten Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical journals. All 12 specialty publications from the JAMA Network ranked among the top 10 in Journal Impact, with eight ranking in the top three for their respective

specialties. And finally, we expanded the AMA's social impact strategy while helping to improve the lives of residents in our home city with a \$3 million multi-year investment in West Side United.

Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (mainly due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance.

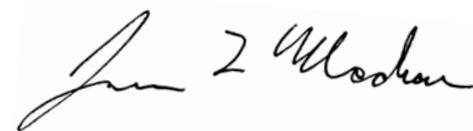
With unparalleled advocacy and engagement, strengthened by our industry-leading research, education and tools, the AMA continues to redefine what it means to be the physicians' powerful ally in patient care. Through challenges and change, in times of crisis and calm, the AMA is committed to physicians, patients and advancing medical practice—and we will never back down.



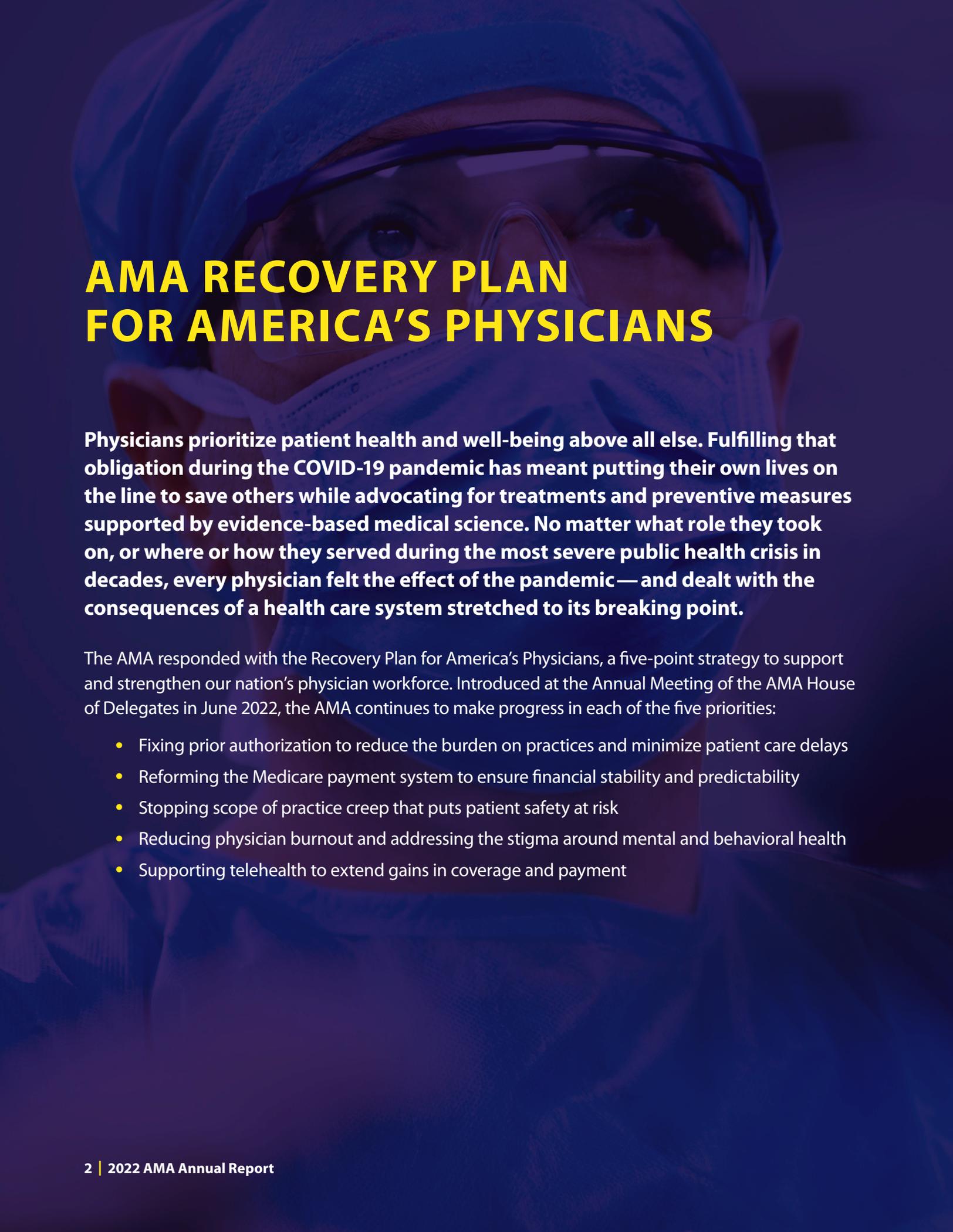
Sandra Adamson Fryhofer, MD
Chair, Board of Trustees



Michael Suk, MD, JD, MPH, MBA
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President



AMA RECOVERY PLAN FOR AMERICA'S PHYSICIANS

Physicians prioritize patient health and well-being above all else. Fulfilling that obligation during the COVID-19 pandemic has meant putting their own lives on the line to save others while advocating for treatments and preventive measures supported by evidence-based medical science. No matter what role they took on, or where or how they served during the most severe public health crisis in decades, every physician felt the effect of the pandemic—and dealt with the consequences of a health care system stretched to its breaking point.

The AMA responded with the Recovery Plan for America's Physicians, a five-point strategy to support and strengthen our nation's physician workforce. Introduced at the Annual Meeting of the AMA House of Delegates in June 2022, the AMA continues to make progress in each of the five priorities:

- Fixing prior authorization to reduce the burden on practices and minimize patient care delays
- Reforming the Medicare payment system to ensure financial stability and predictability
- Stopping scope of practice creep that puts patient safety at risk
- Reducing physician burnout and addressing the stigma around mental and behavioral health
- Supporting telehealth to extend gains in coverage and payment

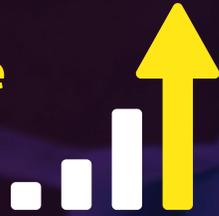
The AMA's progress on these goals in 2022 set the stage for even **greater success** in the future.



Fixing prior authorization

The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by the U.S. House of Representatives in September. Its provisions were developed from the consensus statement on prior authorization reform that the AMA helped draft. The AMA represented the interests of physicians in a federal regulatory task force exploring methods to streamline the prior authorization process. The AMA also played a key role in the successful adoption of prior authorization reform laws in five states and laid the groundwork for 2023 reform efforts in dozens more states.

Reforming the Medicare payment system



The AMA has been leading a multiyear effort to bring about Medicare payment models that give physicians greater flexibility in care delivery, minimize administrative burdens that detract from patient care, and improve the financial viability of physician practices. In 2022, we led a robust advocacy campaign that was joined by more than 150 organizations representing more than 1 million physicians that succeeded in minimizing the 8.5% cuts slated for 2023.

The fight is far from over. Although physicians face a 2% reduction in Medicare payment in 2023, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the pay-as-you-go sequester tied to the American Rescue Plan Act.

The AMA continues to advocate for comprehensive Medicare payment reform and a rational system that is clinically relevant, less administratively burdensome, provides real opportunities for participation in new payment models, and provides stability and financial viability for large and small, as well as urban and rural, physician practices. Principles developed by the AMA to guide Medicare payment reform were endorsed by more than 120 medical societies.



Fighting scope creep

The AMA scored more than 40 state-level

victories by working in partnership with state medical associations and national medical specialty societies. Pressing the fight for patient safety, we stopped bills that would have expanded the scope of practice for nurse practitioners and other APRNs, helped defeat legislation nationwide that would have allowed physician assistants to practice independently without physician oversight, and turned away measures allowing pharmacists to prescribe medications and optometrists to perform surgery.

The AMA continues to aggressively urge the Department of Veterans Affairs to reject the inappropriate scope of practice expansions outlined in the Federal Supremacy Project while advocating as strongly as ever in favor of physician-led teams and against improper scope expansions in all 50 states and the District of Columbia.

Reducing physician burnout



The AMA helped secure enactment of the Dr. Lorna Breen Health Care Provider Protection Act, which enables a broad range of essential physician wellness resources, including evidence-based programs dedicated to improving mental health and resiliency. In addition, the AMA helped build coalitions to strip away stigmatizing questions about mental health and substance abuse disorders on licensure applications. Multiple medical boards and health systems made changes based on AMA recommendations. The AMA also continues to advance strategies organizations can employ to boost professional satisfaction and personal well-being. Finally, the AMA continues to provide tools to address the contributors to burnout in its STEPS Forward series, including a Saving Time Playbook, and a toolkit to address disproportionate impact on patients and physicians called Racial and Health Equity: Concrete STEPS for Health Systems.



Supporting telehealth gains

As evidenced by its tremendous growth during the COVID-19 pandemic, the AMA believes telehealth is a crucial element of effective health care delivery. That's why we continue to work to expand telehealth research, resources and policies while boosting the tools, support and expertise we offer physicians looking to integrate telehealth services into their practices without financial risks or penalties.

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We also launched model legislation that states can use to advance telehealth coverage and policies, and further supported telehealth expansion by producing curated webinars, hosting interactive information exchanges and virtual discussion sessions, and by expanding our already-impressive library of print and online resources promoting evidence-based telehealth services to now include strategies to advance health equity in virtual care.

AMA highlights

The year 2022 was one of much progress across many meaningful initiatives led by the AMA, from advocacy to education and from health equity to blood pressure management. Here are some highlights of our organization's important work during 2022.

The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports in 2022 relating to physician burnout and improving professional satisfaction and practice sustainability. And the AMA Steps Forward Program exceeded 1.6 million lifetime users with new training programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and four videos.

The AMA expanded its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program, honoring nearly 30 health care organizations that represented more than 80,000 physicians.

**30 million
unique
visitors**

to our flagship website, a 10% increase from the record-setting performance the previous year.

In the face of a worsening drug-related overdose and death epidemic, the AMA continued to fight to remove barriers to evidence-based care for people with substance use disorders, patients with pain and increase access to harm reduction initiatives. Thanks, in part, to AMA advocacy, Congress removed the federal "X-waiver" requirement to prescribe buprenorphine in-office for treating opioid use disorder; the Centers for Disease Control and Prevention (CDC) eliminated arbitrary, numeric thresholds from its revised 2022 opioid prescribing guidelines; and the U.S. Food and Drug Administration (FDA) removed barriers for harm reduction organizations to directly purchase and distribute naloxone. AMA advocacy also played a role in the National Association of Insurance Commissioners' efforts to increase health insurers' compliance with state and federal mental health and substance use disorder parity laws, as well as new laws being enacted in multiple states that decriminalized fentanyl test strips and other drug testing supplies and equipment.

The industry-leading AMA Ed Hub online education portal continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The stable of external education providers grew by 10 to encompass 35 organizations with the addition of the American Board of Pediatrics and the American Academy of Allergy, Asthma and Immunology, among others.

The AMA, led by its Center for Health Equity, strengthened its physician engagement with the launch of seven new educational modules published on the AMA Ed Hub learning platform that focus on strategies to advance equity through quality and safety improvements.

The AMA launched the “In Full Health Learning and Action Community to Advance Equitable Health in Innovation” initiative, building upon the expertise of 17 external collaborations to create three AMA Ed Hub learning modules and the “Equitable Health Innovation Solutions” toolkit.

The AMA developed an mpox resource page to provide physicians with updated information on testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar detailing the tecovirimat (TPOXX) antiviral. And the AMA again collaborated on the annual bilingual “Get My Flu Shot/Vacunate Contra la Influenza” campaign, and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying on track with COVID-19 vaccines.

6 million
views on our
AMA Ed Hub™
digital education platform.

The launch of the AMA’s new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services convert ideas and leverage AMA-published content into transformative innovations. A new self-service portal gave physicians the ability to license CPT code sets through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak and ongoing releases for specific COVID-19 vaccines. The AMA also developed revised versions of an initial 20 illustrations for the 2023 CPT PRO Book, reflecting the diversity of our patients.

2.7 million YouTube views

2x the total from 2021.

To close the gap in blood pressure management training within medical schools, the AMA launched a three-part eLearning series, supported by a one-year grant program to monitor the impact of this new training. AMA policy guidance led to four state Medicaid programs increasing access for self-measured blood pressure by covering home-use devices and clinical support services. AMA added four more health care organizations to its growing list of AMA MAP BP™ implementation sites and announced exciting results of one implementation site, Cook County Health on Chicago's West Side, which reported that blood pressure control rates increased by 13 percentage points across 11 practice sites. Additionally, the AMA also trained more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's community support included an additional \$3 million multi-year commitment to West Side United, a community-based collaborative that is addressing determinants of health and reshaping economic vitality on Chicago's West Side.

First published in March 2022 as part of the AMA's MedEd Innovation Series, the "Coaching in Medical Education Handbook" quickly sold out. Now in its second printing, this instructor-focused guide outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical education and training books since its release.

The AMA published "Protecting the Education Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to support educators amid extreme stress and which formed the basis of the *Educator Well-Being in Academic Medicine* book published in December.

In cases ranging from COVID-19 standards of care to firearm regulations, the AMA continued to fight for physicians and patients in state and federal courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes.

The AMA joined an Association of American Medical Colleges-led U.S. Supreme Court amicus brief in the *Students for Fair Admissions v. Harvard* and *Students for Fair Admissions v. University of North Carolina* cases in support of the consideration of race in higher education admissions. Together with the American Academy of Pediatrics, the AMA submitted an amicus brief urging the U.S. Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs promoting access to reproductive care and opposing government interference in the patient-physician relationship.

600,000
AMA
podcast
downloads

175 billion
AMA media
impressions

representing \$1.6 billion in estimated
advertising value to the organization.

The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical assistance to physician practices seeking to deliver integrated care to patients. This effort builds on the success of the Overcoming Obstacles series with several new webinars on topics such as assembling a behavioral health integration care team and addressing physician and patient mental health.

The AMA relaunched its popular Physician Innovation Network digital platform, which now has more than 18,000 collaborators and 30 industry partners, to improve user experience and more effectively connect physicians with technology innovators.

Following up on extensive research that identified the benefits physicians valued most in a disability product, AMA Insurance launched two popular enhancements to this line, including a level-rated premium.

Management's discussion and analysis

Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As physicians' powerful ally in patient care, the AMA delivers on this goal by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, talent and engagement.

2022 accomplishments were led by the launch of the AMA Recovery Plan for America's Physicians, an ambitious roadmap to renewing our country's commitment to physicians—and ensuring their needs are met—so patients can receive the high-quality care they deserve. The plan focuses on five key goals to re-build health care so that it works better for physicians and all those they serve: 1) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 2) reforming Medicare payment to promote thriving physician practices and innovation; 3) stopping scope creep that threatens patient safety; 4) reducing physician burnout and addressing the stigma around mental health; and 5) supporting telehealth to maintain coverage and payment. Advocacy results included achieving more than 35 state-level scope of practice victories in partnership with the Federation and extending telehealth coverage into 2024, as well as minimizing the impact of the scheduled 8.5 percent Medicare payment cuts. Professional Satisfaction and Practice Sustainability expanded its successful programs to reduce burnout in health systems, based on peer-reviewed studies and research.

The AMA, like all other organizations, recognized in early 2020 that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty, including a freeze on hiring and elimination of travel, among other measures. AMA lifted the freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 due to the very tight job market. The lower staffing levels and limited travel garnered substantial savings. These savings are temporary in nature and drove unusually high operating income for AMA during 2020 through 2022 but are not expected to recur after full return to normal activities in 2023.

Pro forma net operating results

(in millions)



*Excluding the \$36.2 million non-cash pension termination charge

AMA's 2023 budget assumes that these temporary savings will not recur, and coupled with expansion of certain programmatic areas, expenses will increase to normal levels, resulting in operating income at the board-approved policy level.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on core mission activities and strategic arcs while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

The following pages discuss the 2022 consolidated financial results as compared to 2021. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings in the first half of 2022 were major factors in spending levels running \$40 million less than budget. At the same time, recurring revenue rose by approximately \$19 million. In addition, the liquidation of a subsidiary and recognition of one-time deferred revenue and costs added \$11.6 million to the 2022 net results. Looking ahead to 2023, AMA does not expect to attain the same level of expense savings and future results are expected to be more modest.

In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a \$38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a \$2 million noncash tax benefit to income tax expense that was previously reported as a non-operating credit.

Excluding the \$36.2 million noncash pension termination expense (net of the \$2 million tax credit), AMA would have reported \$23.4 million in net operating income for 2019.

Results discussed below reflect AMA's actual results from operations in 2022 as compared to 2021. Any pro forma charts exclude the impact of the pension termination on 2019 results.

Revenues

In 2022, total revenue improved by \$33.7 million over the prior year, due to continued growth in AMA's royalties and a one-time recognition of \$14.3 million in deferred revenue from a customer contract in a subsidiary company of Health2047, Inc. (Health2047) upon liquidation of the subsidiary. Most other revenue categories were either slightly down or unchanged for the year.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2022, impacted in large part by higher interest rates. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues-paying members decreased slightly in 2022 by 0.9 percent, after 11 years of consecutive growth in membership. During that 11-year period, AMA dues-paying membership increased by more than 75,000.

Dues revenue decreased by 2.9 percent as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2022, cost of products sold and selling expenses increased \$4.7 million from the prior year, of which \$2.7 million was for one-time recognition of deferred costs related to the Health2047 subsidiary's recognition of deferred revenue noted above. The remaining increase was largely a function of commodity price and postal rate increases for paper and distribution.

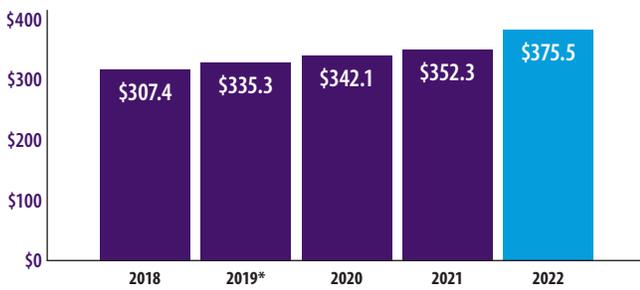
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased \$29 million to \$462.8 million in 2022, with revenue improvements from royalties and the one-time recognition of the Health2047 subsidiary's deferred revenue and costs accounting for most of the change.

Pro forma general and administrative expenses

(in millions)



*Excluding the \$38.2 million non-cash pension termination charge

General and administrative expenses rose only \$23.2 million in 2022, or 6.6 percent, when compared to 2021. This was substantially less than the budgeted increase for 2022, with nonrecurring savings related to staffing, professional services and travel.

Compensation and benefits were largely unchanged in 2022, increasing \$1.4 million, or less than one percent. Compensation, including temporary help, was \$5.8 million higher in 2022, a 3.6 percent increase which was mainly a function of annual merit increases. Fringe benefit costs increased \$2.5 million in total primarily due to higher medical and payroll tax expenses, continuing a post-pandemic trend from 2021. Recruiting costs also increased as an unusually large number of open positions were under recruitment in 2022. Incentive compensation declined \$7.8 million, offsetting most of the above increases, as some key performance indicators were not achieved in 2022 and others were met but not exceeded.

Occupancy costs were up slightly as operating costs rose with a return to office in late 2022 as well as the impact of higher property taxes. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA will relinquish one full floor of office space beginning in 2023 upon payment of a termination penalty. The cash savings over the remaining lease period, including operating expenses and property taxes and net of the penalty, are estimated to be in excess of \$8 million.

Travel and meeting costs increased by \$11.1 million in 2022, as AMA resumed in-person meetings and travel mid-year.

Technology costs were up \$1.5 million in 2022, largely related to continued development of the AMA Ed Hub, JAMA Network initiatives and implementation of the Insurance Agency's new policy administration system.

Marketing and promotion costs rose \$3.2 million in 2022, mainly for marketing and media costs related to the launch of AMA's Recovery Plan for America's Physicians and membership solicitation.

Outside professional services increased \$0.5 million in 2022, due in part to Advocacy conducting a bi-annual Physician Practice Expense survey as well as costs for the "Stop Medicare Cuts" campaign early in 2022.

A \$5.2 million increase in other operating expenses was driven by a \$2.2 million increase in grants and contributions, of which a \$1 million increase is for various grants sponsored by the Center for Health Equity and a \$0.7 million increase is for the Accelerating Change in Medical Education (ACE) Consortium grants. Continued growth in the use of online solutions across a number of business units, as well as price increases, resulted in online product subscription costs increasing \$1.7 million during 2022.

Operating results before income taxes

The AMA reported \$87.3 million in pre-tax operating income in 2022 compared to \$81.5 million in 2021. Both years reflect substantially reduced expenses due to pandemic restrictions on travel and meetings, staffing freezes and tight labor markets. A \$33.7 million increase in revenue was only partially reduced by cost of products sold and general and administrative expense increases described above.

Income taxes

Taxes increased \$0.8 million in 2022 when compared to 2021. The 2021 tax provision included a \$1.2 million credit reflecting a reversal of a previously established reserve for taxes deemed unnecessary due to completion of tax audits. The absence of the credit in 2022 was partially offset by the effect of lower taxable income in one of the subsidiaries.

Net operating results

Net operating income was \$82.9 million in 2022 compared to \$77.9 million in 2021, driven mainly by improved revenues net of expense increases.

Non-operating items

The AMA reported a \$115.1 million loss in the fair value of its portfolio during 2022 after an \$82.8 million gain in 2021. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include \$3.5 million and \$3.9 million in postretirement plan interest expense and recognized actuarial losses and prior service credits for 2022 and 2021, respectively.

Revenue (less than) in excess of expenses

Expenses exceeded revenues by \$35 million in 2022, a combination of \$82.9 million in operating income, the \$115.1 million loss in fair value in the portfolio and \$2.8 million in other non-operating expenses. Revenues exceeded expenses by \$157.4 million in 2021, a combination of \$77.9 million in operating income, an \$82.8 million gain in fair value in the portfolio and \$3.3 million in other non-operating expenses.

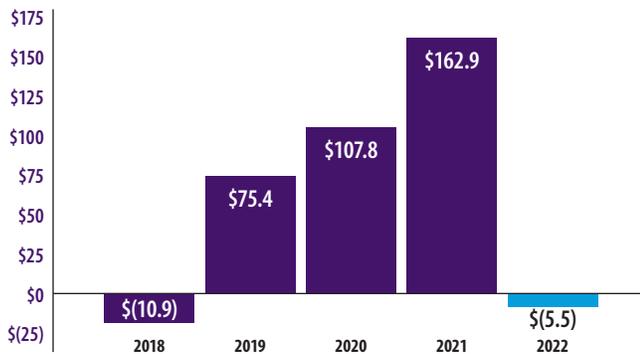
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2022, AMA recorded a \$29.4 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses for the plan to operating expense and income tax. The gain resulted primarily from higher interest rates reducing the present value of plan liabilities.

In 2021, AMA recorded a \$5.6 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses and prior service credits for the plan to operating expense and income tax. The gain resulted from higher interest rates and changes in participants, offset by an increase in baseline claims costs.

Change in total association equity

(in millions)



The AMA reported a \$5.5 million decrease in association equity in 2022. This reflects the amount by which expenses exceeded revenues, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small increase in donor-restricted equity.

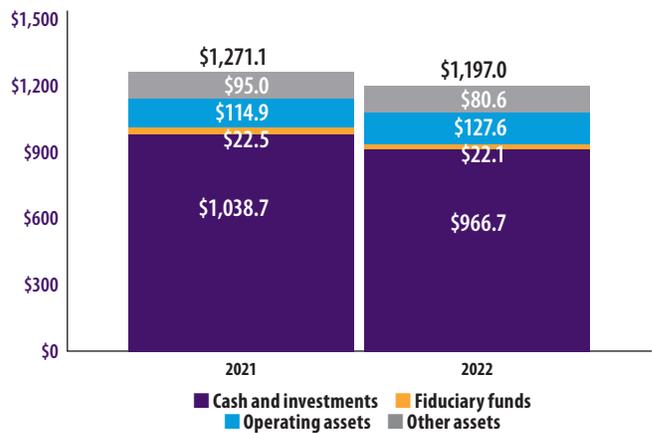
The AMA reported a \$162.9 million increase in association equity in 2021. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)



The AMA's total assets decreased \$74.1 million in 2022.

This includes a \$72 million decrease in cash and investments resulting from \$45.4 million in free cash flow minus a \$115.1 million loss in the fair value of investment securities and \$2.3 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased \$12.7 million in 2022, primarily due to an increase in accounts receivable and prepaid expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset over the life of the lease as well as the impact from the headquarters' lease contraction noted above. Property and equipment net book value also decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased \$52.6 million in 2022, led by decreases in the postretirement health care plan liabilities, lease liability and accrued payroll. The postretirement health care plan liability decrease was a function of the impact of higher interest rates on the present value of plan liabilities. The lease liability change includes a \$2.3 million reduction in the present value of the headquarters liability resulting from exercising the contraction option noted above.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

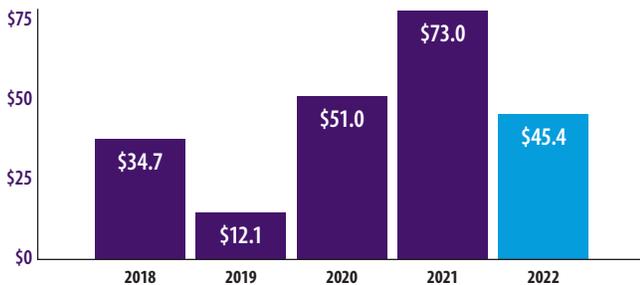
Cash flows

Cash, cash equivalents and donor-restricted cash increased \$1.4 million in 2022 and decreased \$2.9 million in 2021. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

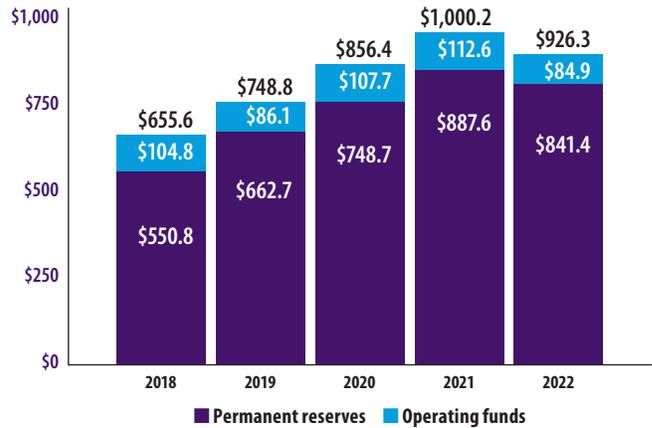


Free cash in 2022 totaled \$45.4 million, substantially less than the 2021 results, driven mainly by changes in operating assets and liabilities.

Reserve portfolio

Reserves

(in millions)



The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2022, the reserve portfolio's value was \$841.4 million compared to \$887.6 million in 2021, a \$46.2 million decrease. That decrease was mainly the result of a \$108.1 million loss in the fair value of the reserve portfolio offset by a \$61.5 million transfer of 2021 excess operating funds to reserves. Operating funds totaled \$84.9 million in 2022, down \$27.7 million from 2021.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all current operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. Prior year financial results have been restated to be consistent with the current year reported results for each group.

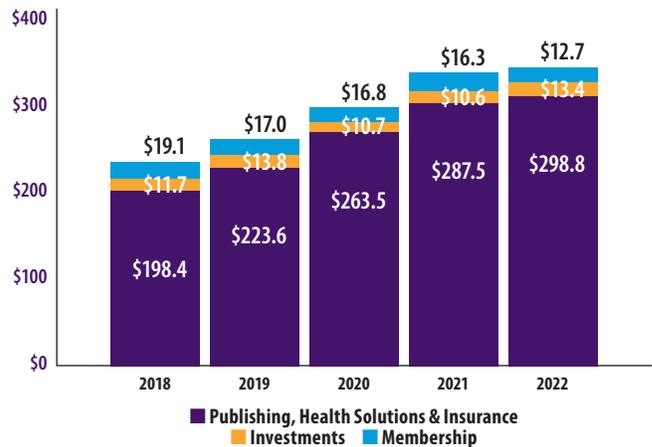
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues include the gross dues revenue collected, reduced by any commissions paid to state societies, and equal the membership dues revenue reported on the statement of activities.

After 11 consecutive years of increases in the number of dues-paying members, AMA experienced a small decrease in total membership in 2022, as the number of dues paying members declined by 0.9 percent. This was driven largely by a drop in student membership which was unfavorably impacted by limitations on in-person recruiting on campuses, while physician membership held steady. Membership continues to focus on expanding use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and more effectively reaching physicians through expanded programmatic activities.

Dues revenue was \$33.8 million, a \$1 million decrease from 2021. Although the number of physician memberships remained steady, growth in lower dues paying categories was only partially offset by the decline in individual direct member categories. Interest expense on lifetime memberships was \$0.1 million in 2022 and zero in 2021. Membership substantially expanded its marketing and solicitation efforts during 2022, with a \$1.9 million increase in marketing costs, accounting for most of the \$2.5 million cost increase. Membership's contribution margin decreased \$3.6 million in 2022, a combination of the revenue decline and cost increases.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In recent years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased \$1.8 million in 2022, with declines in most revenue lines except open access fees. The prior year had included two large one-time purchases of reprints and journal backfiles totaling \$2.4 million which accounted for most of the decline. Expenses rose \$5.2 million during 2022, with approximately \$1.3 million related to inflationary cost increases on paper, printing and distribution. The remaining cost increases occurred across most expense categories. The contribution margin thus declined by \$7 million to \$2.1 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2022, up \$3.5 million when compared to 2021, driven in large part by a major compliance effort to upgrade existing customer contracts from development contracts to full licenses. Expenses were up \$1.1 million driven by higher compensation, increased technology costs and resumption of travel. The resulting contribution margin rose by \$2.4 million in 2022 to \$54.3 million.

AMA-published books and coding products, such as CPT® books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by \$18.6 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. Phasing in previous pricing model changes was also a factor. Coding book sales declined slightly in 2022 as the move from print products to digital continues to adversely impact print product sales. Expenses were down slightly in 2022, driven by reduced use of outside professional services. The contribution margin increased by \$19.4 million to \$228.5 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenues declined by \$1.6 million in 2022, mainly due to a second decrease in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers. The Agency, as broker, receives a commission on insurance policies sold. Expenses were up \$0.6 million mainly due to technology costs related to development of a new customer facing platform. The contribution margin declined to \$17.8 million from \$20 million in the prior year.

Other business operations net expenses were up \$1.3 million in 2022, which included \$0.7 million in one-time costs.

In total, Publishing, Health Solutions & Insurance contribution margin was \$298.8 million, up \$11.3 million from 2021.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was \$14.1 million in 2022, a \$2.8 million increase over the prior year. Dividend and interest income continued to improve in 2022, impacted in part by higher interest rates. The contribution margin also increased by \$2.8 million as expenses were unchanged.

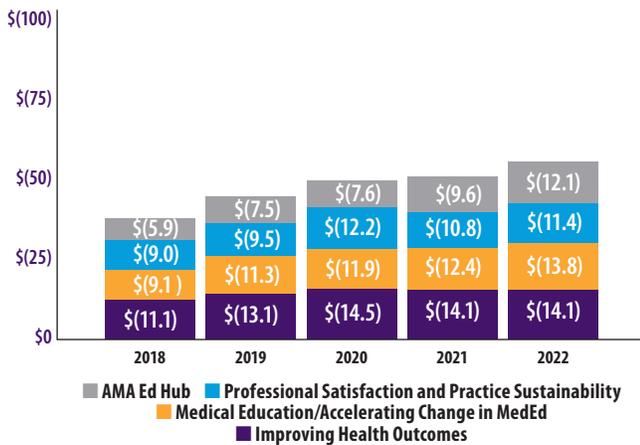
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2022, AMA reported a net loss of \$115.1 million, compared to an \$82.8 million gain in 2021. The total investment return, including investment income, on the reserve portfolios was negative 10.5 percent, better than the 13.1 percent loss in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education including Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO focuses on confronting two of the nation’s most prevalent issues: cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at-risk patients to in-person or online diabetes prevention programs (DPPs). In 2022, the AMA completed a six-year public awareness campaign with the CDC and the Ad Council, reaching 12.5 million individuals who took an online prediabetes risk test.

The AMA has developed online tools and resources using the latest evidence-based information to support physicians to help manage their patients’ high blood pressure (BP). In 2022, to improve the identified gap in BP measurement training in medical schools, IHO developed a three-part e-learning series and hosted a grant program to help embed and monitor the success of the training.

The main focus during 2022 was on hypertension outcome goals as progress continues on implementation of cloud-based M.A.P. BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. Since 2019, the AMA has worked with forty-six HCOs across

20 states to help them implement AMA M.A.P. BP. Additionally, the AMA is currently testing new ways to disseminate M.A.P. BP through population health channel partnerships to help serve health care organizations that care for historically marginalized and minoritized populations. Net expenses were unchanged in 2022.

Advancing Professional Development includes Medical Education/ACE and the AMA Ed Hub.

While the undergraduate medical school consortium grants successfully concluded in 2018, all 32 consortium schools have continued collaboration and new schools have been added to the ACE Consortium each year through focused innovation grants. The consortium of schools has been substantially expanded and now acts as a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

In 2019, the methods and learning from the undergraduate consortium initiative were extended to a new multi-year grant program on graduate medical education, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work.

One of the key outcomes of the ACE Consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2022, Medical Education convened its first Precision Education Summit with a goal of advancing a conceptual model of precision education to optimize lifelong learning for physicians. This will be the next phase of AMA’s critical education transformation. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses increased \$1.4 million in 2022 reflecting resumption of in-person meetings and travel as well as payment of ACE grants previously deferred during the pandemic.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and educational services that support lifelong professional development. The AMA Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets and established internal development plans enterprise-wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The AMA Ed Hub also gives doctors and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical,

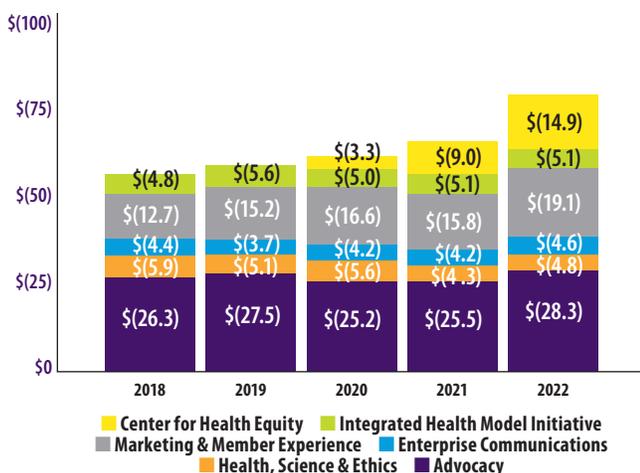
practice transformation and professionalism topics. The number of external education providers on the platform grew by ten organizations to 35 organizations in 2022. Net expenses were up \$2.5 million in 2022 due largely to growth in staffing and enhancements to the technology platform, including features to support live broadcasting and advance multi-media, as well as expanding real-time credit submission to four additional medical boards.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2022, 220,000 physicians were the direct beneficiaries of PS2 services/interventions, as measured by the number of physicians within participating HCOs utilizing organizational/burnout assessments; within participating HCOs in collaborative training and/or coaching efforts; and within HCOs recognized by the Joy in Medicine Health System Recognition Program. In addition, PS2 launched the Private Practice Simple Solutions Initiative and also led and funded the Behavioral Health Integration (BHI) Collaborative of Federation members to design and launch the BHI Immersion Program. In 2022, net expenses increased \$0.6 million, driven almost entirely by staffing and travel costs.

Core Mission Activities

(in millions)



Core Mission Activities includes six groups: Advocacy; Health, Science & Ethics; Center for Health Equity; Integrated Health Model Initiative (IHMI); Enterprise Communications; and Marketing & Member Experience (MMX).

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Advocacy led a campaign (Reforming Medicare Pay) joined by more than 150 other organizations that helped minimize the 8.5 percent in Medicare payment cuts originally slated for 2023, and continuing to urge Congress for long-term, systemic reform through the AMA's coalition. Other major initiatives included: supporting telehealth by extending Medicare telehealth coverage through 2024; fighting scope creep by achieving more than 35 state-level scope of practice victories in strong collaboration with Federation partners; reducing physician burnout by advocating in support of passage of the Dr. Lorna Breen Health Care Provider Protection Act, which provides essential physician wellness resources and by leading a national campaign that enacted multiple state laws, changed licensing and changed credentialing questions; and tackling prior authorization by successfully advocating for unanimous passage of a federal Medicare Advantage prior authorization reform bill in one chamber during the 117th Congress, and helping to enact prior authorization reform laws in Michigan, Georgia and Iowa. In 2022, Advocacy net spending increased \$2.8 million, primarily compensation expenses, travel and meeting costs as in-person meetings resumed as well as campaign costs to stop Medicare cuts.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates (HOD) providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the AMA Journal of Ethics, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in Group Operating Results). This group continued to lead the AMA's COVID-19 efforts during 2022 by providing subject matter expertise and content, and in conjunction with the Ad Council and CDC, updated and launched the annual campaign to get vaccinated against seasonal flu. Net expenses increased \$0.5 million in 2022, due to limited staff expansion and higher costs in the grant administration unit.

The AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health Equity (CHE). The focus of this group is to elevate AMA's public role and responsibilities to improve health equity. In 2022, CHE expanded its efforts to establish an AMA presence in the health equity research literature with the publication of seven Social Justice Education Ed Hub modules and the continuation of the Prioritizing Equity Series; launched the *In Full Health Learning and Action Community to Advance Equitable Health in Innovation* that prioritizes investment in health innovations developed by, with, and for historically marginalized communities; launched the Peer Network for Advancing Equity through quality and safety in collaboration with Brigham & Women's Hospital and The Joint Commission to help health systems apply an equity lens to all aspects of quality and safety practices; and announced Rise to Health, a national coalition for equity in health care, co-led with the Institute for Healthcare Improvement. CHE also established AMA as an anchor mission partner for a collaborative on Chicago's west side, West Side United, and continued building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting and developing structural competency learning tools. The continued planned growth of CHE resulted in a \$5.9 million increase in net expenses in 2022.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR), the Gravity Project and others. In 2022, IHMI completed development of a Self-Measured Blood Pressure (SMBP) software and services solution and gathered baseline data from a pilot site related to pilot population. IHMI net expenses were largely unchanged in 2022.

MMX extends the reach and impact of AMA's mission and advocacy initiatives and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. In 2022, more than 30 million unique individuals accessed AMA's website, a 20 percent increase over the record number of users in the prior

year which was driven by AMA's COVID-19 Resource Center and other compelling editorial, video and social content. The launch of AMA's Recovery Plan for America's Physicians alone generated nearly five million website users. Net expenses increased \$3.3 million in 2022, largely staffing and media marketing expenses for the recovery plan launch.

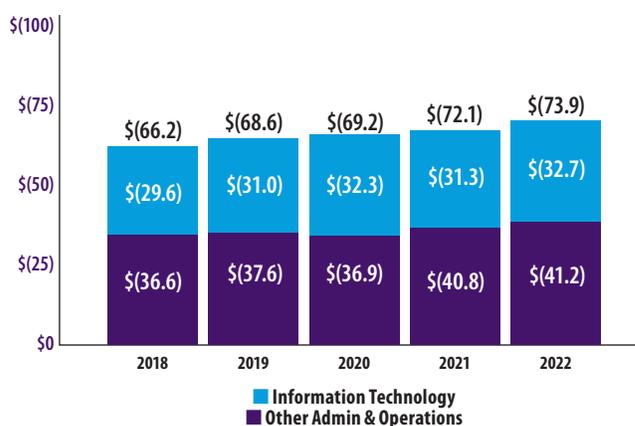
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science to embed equity, innovation and advocacy across the AMA's strategic work throughout health care. Net expenses were up \$0.4 million in 2022, mainly related to activities celebrating AMA's 175th anniversary.

Governance

Governance includes the Board of Trustees and Board Operations, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2022, Governance net spending was up \$5.6 million, mainly for resumption of in-person meeting and travel costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs and Core Mission Activities, as well as other operating groups. Net expenses were up slightly in 2022, an increase of \$1.8 million, or 2.5 percent, mainly inflationary cost increases.

Affiliated organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2022.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2022, these expenses totaled \$20.5 million, down from \$31.1 million in 2021. Lower incentive compensation was the main factor in the decrease.

Health2047 and subsidiaries

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. After the initial stage, it is expected that these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. At some point in the future, the spinoffs will be sold or liquidated, at which time, AMA could expect to receive a financial return.

Since 2017, Health2047 has spun off or invested in 11 companies: Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS), Zing Health Enterprises, LP (Zing), Medcurio, Inc. (Medcurio), Phenomix Sciences, Inc. (Phenomix), Sitebridge Research, Inc. (Sitebridge), Emergence Healthcare Group, Inc. (Emergence), Heal Security, Inc. (Heal), Recovery Exploration Technologies, Inc. (RecoverX) and Scholar Rx, Inc. (Scholar Rx).

In 2022, Health2047 liquidated two of these companies, Akiri and HXS, as third-party financing efforts were unsuccessful. Upon liquidation of Akiri, there was an \$11.6 million gain from recognizing deferred revenue and expense for a customer contract entered into and paid in 2017. There was no material gain or loss upon the HXS liquidation.

As of December 31, 2022, Health2047 has an ownership interest in nine companies, including a consolidated subsidiary, FMC, two companies accounted for using the equity method, Heal and Emergence, and six companies accounted for using the cost method, Zing, Medcurio, Phenomix, Sitebridge, RecoverX and Scholar Rx. The footnotes to AMA's financial statements include a detailed discussion on accounting for Health2047 spinoff companies.

Third-party financing is expected to cover most long-term future costs for many of these companies.

Health2047 revenue in 2022 was \$14.3 million, compared to \$1 million in 2021. In 2022, as a result of the Akiri liquidation, Health2047 recognized \$14.3 million in revenue and \$2.7 million in associated costs for creating a custom platform for a customer. Both revenue and expense had been received or incurred in prior years but were deferred until the project was completed or abandoned, which occurred in 2022.

Costs increased \$3.4 million, of which \$2.7 million was the recognition of deferred costs for the custom platform.

Net expenses declined by \$9.9 million in 2022 to \$1.4 million, primarily due to the net \$11.6 million impact from recognizing the deferred revenue and expense discussed above.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues		Margin (expenses)	
	2022	2021	2022	2021
Membership	\$ 33.7	\$ 34.8	\$ 12.7	\$ 16.3
Publishing, Health Solutions & Insurance				
Publishing	65.9	67.7	2.1	9.1
Database Products	66.9	63.4	54.3	51.9
Books and Digital Content	252.1	233.5	228.5	209.1
Insurance Agency/Affinity Products	36.4	38.0	17.8	20.0
Other business operations	-	-	(3.9)	(2.6)
	421.3	402.6	298.8	287.5
Investments (AMA-only)	14.1	11.3	13.4	10.6
Strategic Arcs & Core Mission Activities				
Improving Health Outcomes	-	0.1	(14.1)	(14.1)
Medical Education/Accelerating Change in Medical Education	0.3	0.3	(13.8)	(12.4)
AMA Ed Hub	0.4	0.3	(12.1)	(9.6)
Professional Satisfaction and Practice Sustainability	0.4	0.4	(11.4)	(10.8)
Advocacy	0.5	0.5	(28.3)	(25.5)
Health, Science & Ethics	2.7	2.5	(4.8)	(4.3)
Center for Health Equity	0.1	-	(14.9)	(9.0)
Integrated Health Model Initiative	-	-	(5.1)	(5.1)
Marketing and Member Experience	-	-	(19.1)	(15.8)
Enterprise Communications	-	-	(4.6)	(4.2)
United States Adopted Names Program	3.7	4.0	2.9	3.3
	8.1	8.1	(125.3)	(107.5)
Governance				
Board of Trustees and Board Operations	-	-	(6.5)	(5.2)
House of Delegates, Sections, Special Constituencies & International	0.1	-	(10.0)	(5.7)
	0.1	-	(16.5)	(10.9)
Administration and Operations				
Information Technology	-	-	(32.7)	(31.3)
Senior Executive Management	-	-	(5.6)	(4.7)
General Counsel	-	-	(6.9)	(8.3)
Finance & Risk Management	-	-	(7.7)	(7.8)
Human Resources	-	-	(8.1)	(7.1)
Corporate Services	-	-	(5.6)	(5.4)
Customer Service	-	-	(3.4)	(3.4)
Strategic Insights and Planning	-	-	(3.9)	(4.1)
	-	-	(73.9)	(72.1)
Affiliated Organizations	0.1	0.1	-	-
Unallocated Overhead	1.7	1.8	(20.5)	(31.1)
Health2047 & Subsidiaries	14.3	1.0	(1.4)	(11.3)
Consolidated revenue and income before tax	\$ 493.4	\$ 459.7	87.3	81.5
Income taxes			(4.4)	(3.6)
Consolidated net operating income			\$ 82.9	\$ 77.9

Consolidated financial statements

Consolidated statements of activities

Years Ended December 31

(in millions)	2022	2021
Revenues		
Membership dues	\$ 33.8	\$ 34.8
Advertising	13.3	14.4
Journal print subscription revenues	2.9	3.3
Journal online revenues	30.8	31.2
Other publishing revenue	17.8	18.0
Books, newsletters and online product sales	24.7	25.5
Royalties and credentialing products	293.1	270.5
Insurance commissions	33.2	35.0
Investment income (Note 4)	15.1	11.6
Equity in losses of affiliates (Note 2)	(0.8)	(0.6)
Grants and other income	29.5	16.0
Total revenues	493.4	459.7
Expenses		
Cost of products sold and selling expenses	30.6	25.9
Contribution to general and administrative expenses	462.8	433.8
General and administrative expenses		
Compensation and benefits	234.7	233.3
Occupancy	21.4	21.1
Travel and meetings	14.7	3.6
Technology costs	29.5	28.0
Marketing and promotion	21.3	18.1
Professional services	29.2	28.7
Other operating expenses	24.7	19.5
Total general and administrative expenses	375.5	352.3
Operating results before income taxes	87.3	81.5
Income taxes (Note 9)	4.4	3.6
Net operating results	82.9	77.9
Non-operating items		
Net (loss) gain on investments (Note 4)	(115.1)	82.8
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.5)	(3.9)
Other non-operating income	0.7	0.6
Total non-operating items	(117.9)	79.5
Revenues (less than) in excess of expenses	(35.0)	157.4
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 8 and 9)	29.4	5.6
Change in association equity	(5.6)	163.0
Change in donor restricted association equity		
Restricted contributions	0.4	0.3
Net assets released from restriction	(0.3)	(0.4)
Change in association equity – donor restricted	0.1	(0.1)
Change in total association equity	(5.5)	162.9
Total association equity at beginning of year	894.9	732.0
Total association equity at end of year	\$ 889.4	\$ 894.9

See accompanying notes to the consolidated financial statements.

Consolidated statements of financial position

As of December 31

(in millions)	2022	2021
Assets		
Cash, cash equivalents and donor-restricted cash	\$ 33.5	\$ 32.1
Fiduciary funds (Note 2)	22.1	22.5
Investments in affiliates (Note 2)	8.9	7.0
Accounts receivable and other receivables, net of an allowance for doubtful accounts of \$0.3 in 2022 and \$0.2 in 2021	101.5	88.5
Inventories	2.8	1.7
Prepaid expenses and deposits	11.7	13.0
Deferred income taxes (Note 9)	2.7	4.7
Investments (Note 4)	933.2	1,006.6
Property and equipment, net (Note 6)	33.3	39.6
Operating lease right-of-use assets (Note 10)	39.1	46.0
Other assets (Note 5)	8.2	9.4
	\$ 1,197.0	\$ 1,271.1
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	\$ 16.0	\$ 18.6
Accrued payroll and employee benefits (Note 7)	45.7	54.6
Accrued postretirement healthcare benefits (Note 8)	88.1	117.5
Insurance premiums and other fiduciary funds payable	22.1	22.4
Operating lease liability (Note 10)	65.3	76.7
	237.2	289.8
Deferred revenue		
Membership dues	13.9	14.6
Subscriptions, licensing, insurance commissions and royalties	53.9	69.4
Grants and other	2.6	2.4
	70.4	86.4
Association equity		
Association equity	889.3	894.9
Donor-restricted association equity	0.1	-
Total association equity	889.4	894.9
	\$ 1,197.0	\$ 1,271.1

See accompanying notes to the consolidated financial statements.

Consolidated statements of cash flows

Years Ended December 31

(in millions)	2022	2021
Cash flows from operating activities		
Change in total association equity	\$ (5.5)	\$ 162.9
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.2	12.3
Postretirement health care expense	4.6	5.3
Noncash operating lease expense	9.7	10.1
Net loss (gain) on investments	115.1	(82.8)
Equity in losses of affiliates	0.8	0.6
Noncash credit for changes in defined benefit plans other than periodic expense net of tax	(29.4)	(5.6)
Noncash credit from recognition of deferred revenue and costs related to liquidation of subsidiary	(11.6)	-
Bad debt expense	0.1	(0.2)
Other	(1.3)	(1.1)
Changes in assets and liabilities		
Accounts receivable and other receivables	(13.1)	(5.5)
Inventories	(1.1)	0.6
Prepaid expenses and deposits	1.0	(1.8)
Accounts payable, accrued liabilities and income taxes	(22.5)	(9.4)
Accrued postretirement benefit costs	(2.7)	(2.4)
Deferred revenue	(1.7)	(1.4)
Net cash provided by operating activities	54.6	81.6
Cash flows from investing activities		
Purchase of property and equipment	(9.2)	(8.6)
Investment in affiliates	(2.3)	(6.3)
Purchase of investments	(538.3)	(662.6)
Proceeds from sale of investments	496.6	593.0
Net cash used in investing activities	(53.2)	(84.5)
Net change in cash, cash equivalents and donor restricted cash	1.4	(2.9)
Cash, cash equivalents and donor restricted cash at beginning of year	32.1	35.0
Cash, cash equivalents and donor restricted cash at end of year	\$ 33.5	\$ 32.1
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	\$ 0.5	\$ -
Noncash investing activities		
Accounts payable for property and equipment additions	\$ 0.3	\$ 0.9

See accompanying notes to the consolidated financial statements.

Notes to consolidated financial statements

For the years ended December 31, 2022 and 2021
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 275 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company and Health2047 Inc. (collectively, the AMA).

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2022. Health2047 controls and therefore consolidates the results of two companies, First Mile Care, Inc. as well as Akiri, Inc. (Akiri). Akiri was liquidated during 2022 resulting in recognition of \$14.3 million of deferred revenue, in grants and other income, and \$2.7 million of deferred costs, in cost of products sold and selling expenses, related to completion of a customer contract entered into during 2017.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The companies accounted for under the equity method of accounting during 2022 are: HXSquare, Inc. (formed in January 2019 and liquidated in February 2022), Emergence Healthcare Group, Inc. (formed in January 2021), Heal Security, Inc. (formed in February 2021), and Recovery Exploration Technologies, Inc. (formed in August 2021). During 2022, the AMA ceased application of the equity method to account for the investment in Recovery Exploration Technologies, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2022, AMA ownership interest is 20.1% in Emergence Healthcare Group, Inc. and 33.3% in Heal Security, Inc. The book value of the two investments accounted for under the equity method, net of convertible debt, at December 31, 2022 is \$1.8 million.

In addition, at December 31, 2022, AMA has an ownership interest of 3.6% in Zing Health Enterprises, LP (formed in May 2020), 12.1% in Medcurio Inc., (formed in February 2020), 12.6% in Phenomix Sciences, Inc. (formed in August 2020), 11.3% in Recovery Exploration Technologies, Inc., 18.8% in Sitebridge Research, Inc. (formed January 2021), and 6.0% in Scholar Rx, Inc. (formed December 2022). The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. The book value of the six investments carried at cost at December 31, 2022 is \$7.1 million.

Health2047 had investments in ten companies or limited partnerships as of December 31, 2021, including two that were consolidated, First Mile Care, Inc. and Akiri, Inc. The companies accounted for under the equity method of accounting during 2021 were: HXSquare, Inc., Phenomix Sciences, Inc., Emergence Healthcare Group, Inc., Heal Security, Inc., and Recovery Exploration Technologies, Inc. During 2021, the AMA ceased application of the equity method to account for the investment in Phenomix Sciences, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2021 AMA ownership interest was 20% in HXSquare, Inc., 21.9% in Emergence Healthcare Group, Inc., 33.3% in Heal Security, Inc. and 22.6% in Recovery Exploration Technologies, Inc. The book value of the four investments accounted for under the equity method, net of convertible debt, at December 31, 2021 was \$2.4 million.

In addition, at December 31, 2021, AMA had an ownership interest of 5.5% in Zing Health Enterprises, LP, 11.8% in Medcurio Inc., 14.4% in Phenomix Sciences, Inc. and 18.8% in Sitebridge Research, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the four investments carried at cost at December 31, 2021 was \$4.6 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of separate unincorporated entities with \$2.3 million and \$2.8 million held at December 31, 2022 and 2021, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was \$96.3 million and \$85.1 million as of December 31, 2022 and 2021, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes.

3. New accounting standards update

In August 2020, Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2020-06, *Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40)*—*Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments in this update are expected to improve, simplify, and enhance the financial reporting requirements for convertible instruments and contracts in an entity's own equity for all entities, including private companies. The new guidance is effective for the AMA for the year ending December 31, 2024. AMA does not expect there to be a material impact on the consolidated financial statements upon adoption.

4. Investments

Investments include marketable securities, venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2022, and 2021 totaled \$80.1 million and \$76.4 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2022	2021
Level 1 – Quoted prices in active market for identical securities		
Equity securities	\$ 419.9	\$ 474.6
Fixed-income mutual funds	27.1	48.9
	447.0	523.5
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	106.7	116.0
U.S. government and federal agency	264.8	269.1
Foreign government	24.7	28.7
U.S. state government	0.1	0.2
	396.3	414.0
Other investments measured at NAV –		
Private equity and venture capital funds	89.9	69.1
Investments	\$ 933.2	\$ 1,006.6

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2022	2021
Investment dividend and interest income	\$ 18.3	\$ 15.1
Management fees	(3.2)	(3.5)
	\$ 15.1	\$ 11.6

Investment non-operating items include:

	2022	2021
Realized gains on investments, net	\$ 6.4	\$ 74.8
Unrealized (losses) gains on investments, net	(121.5)	8.0
	\$ (115.1)	\$ 82.8

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled \$8.2 million and \$9.4 million as of December 31, 2022 and 2021, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2022	2021
Leasehold improvements	\$ 39.0	\$ 38.7
Furniture and office equipment	19.9	19.7
Information technology		
Hardware	12.9	13.5
Software	94.4	97.6
	166.2	169.5
Accumulated depreciation and amortization	(132.9)	(129.9)
Property and equipment, net	\$ 33.3	\$ 39.6

7. Retirement savings plans

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled \$8.3 million and \$7.9 million in 2022 and 2021, respectively.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2022	2021
Benefit obligation at beginning of year	\$ 117.5	\$ 120.5
Service cost	1.1	1.5
Interest cost	3.1	2.8
Benefits paid	(4.1)	(3.8)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial gain	(30.9)	(4.9)
Accrued postretirement benefit costs	\$ 88.1	\$ 117.5

The postretirement health care plan accumulated losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2022	2021
Actuarial (gains) losses	\$ (9.7)	\$ 21.6

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2022	2021
Discount rate	5.2%	2.8%
Initial health care cost trend	7.0%	6.1%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2046	2045

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2022	2021
Service cost	\$ 1.1	\$ 1.4
Interest cost	3.1	2.8
Amortization of prior service credit	-	(0.3)
Amortization of actuarial loss	0.4	1.4
	\$ 4.6	\$ 5.3

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2022	2021
Actuarial gains arising during period	\$ 30.9	\$ 4.8
Reclassification adjustment for recognition of actuarial loss	0.4	1.4
Reclassification adjustment for recognition of prior service credit	-	(0.3)
Change in unrestricted equity	\$ 31.3	\$ 5.9

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2022	2021
Discount rate	2.8%	2.5%
Initial health care cost trend	6.1%	5.64%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2023	\$ 3.6
2024	3.7
2025	4.1
2026	4.3
2027	4.6
2028–2032	26.0

9. Income taxes

The provision for income taxes includes:

	2022	2021
Operating		
Current	\$ 4.3	\$ 3.7
Deferred	(21.4)	0.1
Valuation allowance	21.5	(0.2)
	4.4	3.6
Tax expense related to credits or charges to equity		
Deferred	1.9	0.3
	\$ 6.3	\$ 3.9

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2022	2021
Net operating loss carryforward	\$ 21.4	\$ -
Benefit plans and compensation	5.2	7.3
Other	0.1	(0.1)
	26.7	7.2
Valuation allowance	(24.0)	(2.5)
	\$ 2.7	\$ 4.7

Cash payments for income taxes were \$4 million and \$6.2 million in 2022 and 2021, respectively, net of refunds.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from five years to 15 years. Most leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate with appropriate notice and termination payments. As any extension, renewal, or termination is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use (ROU) asset or lease liability.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

AMA exercised a contraction option during 2022 reducing the square footage at the main headquarters by approximately 10%, with a contraction penalty. The ROU asset and lease liability were remeasured as of the lease modification date and the impact of the contraction is reflected in the ROU asset and lease liability as of December 31, 2022. ROU assets decreased \$1.3 million, lease liabilities decreased \$2.3 million, with the resulting net gain of \$1 million included as a reduction to other operating expense. AMA also leases copiers and printers in several locations. The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All office and equipment leases are classified as operating leases.

Operating lease costs totaled \$9.7 million in 2022 and \$10.1 million in 2021. Cash paid for amounts included in the measurement of lease liabilities totaled \$13.2 million in 2022 and \$13.1 million in 2021.

The remaining weighted-average lease term is 6.3 years and 7.1 years as of December 31, 2022 and 2021, respectively. The weighted-average discount rate used for operating leases is 5% for both 2022 and 2021.

The maturity of lease liabilities as of December 31, 2022:

2023	\$ 15.3
2024	11.4
2025	11.4
2026	11.6
2027	11.8
2028 and beyond	14.5
Total lease payments	76.0
Less imputed interest	(10.7)
Present value of lease obligations	\$ 65.3

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2022	2021
Financial assets	\$ 966.7	\$ 1,038.7
Less assets unavailable for general expenditures:		
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(841.4)	(887.6)
Financial assets available to meet cash needs for general expenditures within one year	\$ 125.3	\$ 151.1

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2022, the AMA has evaluated all subsequent events through February 10, 2023, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Arcs and Core Mission Activities, Publishing, Health Solutions and Insurance, Membership and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	\$ -	\$ 27.9	\$ -	\$ -	\$ -	\$ 2.7	\$ 30.6
Compensation and benefits	6.4	65.1	-	78.1	78.1	7.0	234.7
Occupancy	0.4	5.7	-	6.9	7.1	1.3	21.4
Travel and meetings	0.1	2.6	-	4.5	7.2	0.3	14.7
Technology costs	1.0	11.0	-	7.1	10.3	0.1	29.5
Marketing and promotion	11.7	0.1	-	7.3	1.6	0.6	21.3
Professional services	0.4	4.2	0.3	17.5	3.8	3.0	29.2
Other operating expense	1.0	5.9	0.4	12.0	4.7	0.7	24.7
2022 total expense	\$ 21.0	\$ 122.5	\$ 0.7	\$ 133.4	\$ 112.8	\$ 15.7	\$ 406.1
Cost of products sold and selling expense	\$ -	\$ 25.9	\$ -	\$ -	\$ -	\$ -	\$ 25.9
Compensation and benefits	5.8	62.4	-	70.1	88.5	6.5	233.3
Occupancy	0.5	5.6	-	6.7	6.8	1.5	21.1
Travel and meetings	-	0.6	-	1.1	1.8	0.1	3.6
Technology costs	1.6	10.4	-	6.3	9.7	-	28.0
Marketing and promotion	9.6	0.4	-	7.5	0.1	0.5	18.1
Professional services	0.1	4.5	0.3	16.6	4.7	2.5	28.7
Other operating expense	0.9	5.3	0.4	8.9	2.8	1.2	19.5
2021 total expense	\$ 18.5	\$ 115.1	\$ 0.7	\$ 117.2	\$ 114.4	\$ 12.3	\$ 378.2

Independent auditor's report

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2022 and 2021, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 10, 2023

Written statement of certification of chief executive officer and chief financial officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2022 and 2021 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 10, 2023

2022–2023 Board of Trustees and Executive Leadership

Board of Trustees

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President

Jesse M. Ehrenfeld, MD, MPH
President-elect

Gerald E. Harmon, MD
Immediate Past President

Bruce A. Scott, MD
Speaker, AMA House of Delegates

Lisa Bohman Egbert, MD
Vice Speaker, AMA House of Delegates

Sandra Adamson Fryhofer, MD
Chair

Willie Underwood III, MD, MSc, MPH
Chair-elect

Bobby Mukkamala, MD
Immediate Past Chair

Michael Suk, MD, JD, MPH, MBA
Secretary

David H. Aizuss, MD

Toluwalase A. Ajayi, MD

Madelyn E. Butler, MD

Alexander Ding, MD, MS, MBA

Willarda V. Edwards, MD, MBA

Scott Ferguson, MD

Drayton Charles Harvey

Marilyn J. Heine, MD

Pratistha Koirala, MD, PhD

Ilse R. Levin, DO, MPH & TM

Thomas J. Madejski, MD

Harris Pastides, PhD, MPH

Executive Management

James L. Madara, MD
CEO and Executive Vice President

Standing Committees

Executive Committee

Dr. Fryhofer, *chair*

Dr. Underwood

Dr. Resneck

Dr. Ehrenfeld

Dr. Harmon

Dr. Suk

Dr. Scott

Dr. Mukkamala

Audit Committee

Dr. Harmon, *chair*

Dr. Aizuss

Dr. Butler

Dr. Madejski

Dr. Pastides

Dr. Scott

Dr. Suk

Awards and Nominations

Dr. Madejski, *chair*

Dr. Ajayi, MD

Dr. Egbert

Mr. Harvey

Dr. Heine

Dr. Koirala

Dr. Levin

Compensation Committee

Dr. Ehrenfeld, *chair*

Dr. Ferguson

Dr. Fryhofer (*ex-officio w/vote*)

Dr. Mukkamala (*ex-officio w/vote*)

Dr. Scott

Dr. Suk

Dr. Underwood (*ex-officio w/vote*)

Finance Committee

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Dr. Aizuss

Dr. Butler

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Dr. Edwards

Dr. Ehrenfeld

Dr. Ferguson

Governance and Self-Assessment Committee

Dr. Harmon, *chair*

Dr. Ehrenfeld

Dr. Fryhofer

Dr. Madejski

Dr. Suk

Note: Drs. Fryhofer, Underwood and Mukkamala serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Resneck serves on all committees as an ex-officio member with vote.



Jack Resneck Jr., MD



Jesse M. Ehrenfeld, MD, MPH



Gerald E. Harmon, MD



Bruce A. Scott, MD



Lisa Bohman Egbert, MD



Sandra Adamson Fryhofer, MD



**Willie Underwood III, MD,
MSc, MPH**



Bobby Mukkamala, MD



Michael Suk, MD, JD, MPH, MBA



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Pratistha Koirala, MD, PhD



Ilse R. Levin, DO, MPH & TM



Thomas J. Madejski, MD



Harris Pastides, PhD, MPH



James L. Madara, MD



REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-23

Subject: AMA 2024 Dues

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1

2

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

3

4

5

6

RECOMMENDATION

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2024 Membership Year

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11

The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed:

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Regular Members	\$ 420
Physicians in Their Fourth Year of Practice	\$ 315
Physicians in Their Third year of Practice	\$ 210
Physicians in Their Second Year of Practice	\$ 105
Physicians in Their First Year of Practice	\$ 60
Physicians in Military Service	\$ 280
Semi-Retired Physicians	\$ 210
Fully Retired Physicians	\$ 84
Physicians in Residency/Fellow Training	\$ 45
Medical Students	\$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-23

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 At the November 2022 Interim Meeting, Board of Trustees Report 3, “Delegate Apportionment and
2 Pending Members,” was considered and referred.

3 4 BACKGROUND

5
6 At the 2018 Interim Meeting, policy was adopted calling for the inclusion of pending members in
7 the delegate apportionment process. Per Board of Trustees Report 1-I-18 pending members are
8 those who at the time they apply for AMA membership are not members and who pay dues for the
9 following calendar year. This typically occurs in the last few weeks of one year, with the
10 individual’s membership becoming active on January 1 of the following year. The policy was
11 refined in Board of Trustees Report 12-A-19 to address issues related to counting such members as
12 well as distinctions between constituent and specialty societies, and the necessary bylaws
13 amendments were adopted at the 2019 Interim Meeting in the Council on Constitution and Bylaws
14 Report 3-I-19. This formed AMA Policy G-600.016, “Data Used to Apportion Delegates,” which
15 also called for an evaluation at A-22. Board of Trustees Report 20-A-22 provided a review on the
16 effects of counting pending members and included six recommendations. One recommendation
17 was adopted which defined the apportionment process for 2023 and was predicated on not counting
18 pending members. (Policy G-600.959 paragraph 1). Recommendation 1 of BOT Report 20-A-22
19 was referred for decision and the remaining recommendations were referred.

20
21 In September 2022, your Board voted to adopt Recommendation 1 of Board Report 20-A-22,
22 which had been referred for decision. By this action pending members would not be counted for
23 apportionment purposes, which was subsequently recorded as paragraph 2 of Policy G-600.959,
24 “Delegate Apportionment and Pending Members.”

25
26 Board of Trustees Report 3-I-22 dealt with the remaining referred items from Board Report 20-A-
27 22. The report included a recommendation to rescind Policy G-600.016. The House of Delegates
28 (HOD) referred the report back to the Board. Also at I-22, the HOD considered Constitution &
29 Bylaws Report 1-I-22 which recommended changes to Bylaw §2.1.1.1 specifying how
30 apportionment would be accomplished for 2023 and recommended deletion of the following
31 sentence, “*The December 31 count will include pending members for purposes of apportionment;
32 however, pending members shall not be recounted the following year absent membership
33 renewal.*” The HOD adopted the bylaw amendment specifying the 2023 apportionment but referred
34 the recommended deletion of the sentence reproduced above. Given the Board’s September action,
35 to no longer count pending members and the adopted bylaw which specifies the process to be used
36 for 2023, the referred sentence although retained in Bylaw §2.1.1.1 has no impact. Furthermore, the
37 amendment adopted by the House includes a sunset provision for the entirety of Bylaw §2.1.1.1 as
38 of December 31, 2023.

1 DISCUSSION

2
3 The original policy adopted by the HOD regarding pending members called for a subsequent
4 evaluation of the policy with recommendations regarding its continuation. This evaluation showed
5 that the intended goals of counting pending members for apportionment of HOD Delegates had not
6 been realized. In addition, your Board believes that counting pending members diminishes the role
7 of active members themselves, devalues other benefits of membership and unnecessarily
8 complicates the apportionment process.

9
10 There is little to no evidence that suggests that the offer to count pending members for
11 apportionment purposes has led to membership gains. Virtually all the pending members identified
12 in the initial adoption of the policy had already joined prior to the implementation of the
13 experiment. Anecdotes suggesting that being counted toward representation in the House of
14 Delegates is a motivation for members to join late in the membership cycle has not been confirmed
15 with data over the trial years. Physicians consistently report valuing the advocacy that emerges
16 from House of Delegates (HOD) policy, not representation in the House of Delegates itself *per se*.

17
18 There may be isolated instances where state delegations at risk for losing a seat in the House may
19 be motivated to recruit pending members, but it would seem these efforts should be undertaken
20 earlier in the membership year to recruit members for the actual year used for apportionment not
21 the following year. In fact, our current bylaws (2.1.1.2.1) provide that if the membership
22 information as recorded at the end of a year warrants a decrease in the number of delegates, the
23 association is permitted to retain their delegate number, without decrease, for an additional year to
24 intensify their recruitment of members. Counting pending members, those who pay dues not for
25 that additional grace year but for the following year, in effect extends the grace period and creates
26 an opportunity for members to join every third year while still being counted for apportionment.

27
28 The notion that pending members gain representation by being counted for apportionment purposes
29 belies the fact that delegates represent the needs of not only members but patients, their sponsoring
30 societies, and the profession, including nonmembers. This is explicitly stated in the [HOD](#)
31 [Reference Manual](#). Pending members are in fact NOT members. Individuals who join late in the
32 year wishing to be represented in the HOD could join for the current year by paying half-year dues.
33 It has been said that counting pending members more fairly apportions delegation count. On the
34 contrary, since representation in HOD is based upon membership numbers, allowing certain
35 societies to inflate their delegate numbers beyond their true proportional representation by
36 including pending members diminishes the vote of other societies that have fulfilled their
37 membership requirements and may be thought to disenfranchise the current members.

38
39 Some delegations hoped that including pending members would increase their number of delegates.
40 Upon implementation virtually all the increase came in the first year of the experiment and few
41 states actually gained delegates even in that initial year. Any increase was short lived as pending
42 members provide a net membership increase only in their initial count. Ultimately, there is no
43 evidence that pending members have any positive effect on apportionment numbers.

44
45 Others have argued that not counting pending members is tantamount to treating them as second-
46 class members. As noted above, they are indeed not members, at least not initially, and once they
47 are members they will be counted just like all other members in the year in which their membership
48 dues apply. Decisions about apportionment need not be linked to more concrete member benefits.
49 In fact, members do begin receiving most membership benefits shortly after the membership
50 decision is made.

1 Although physicians and medical students make the membership decision throughout the year,
2 AMA membership, similar to most every other medical society membership, is calendar year
3 based. For example, medical students, particularly first year students, often join in July or August
4 and most continuing members renew their membership for the following year in November and
5 December. As such, the membership count varies from day to day. Determination of membership
6 count and thus apportionment could theoretically be done on any date but has to be completed on a
7 defined date. The date of December 31 is specified in multiple provisions within our bylaws. The
8 AMA recognizes dues revenue in financial statements for the calendar membership year. Legally,
9 members are listed as members for the calendar year membership designated on the membership
10 application, regardless when submitted and paid.

11
12 Finally, as a practical matter, once someone becomes a pending member, the individual must be
13 tracked across time in perpetuity solely for apportionment lest membership become an on-again,
14 off-again process to game the system. The timing of one's dues payment and one's membership
15 status at the time of that payment affect how and whether one is counted for apportionment
16 purposes. These elements cannot be captured by AMA's membership accounting system across a
17 potential 40- or 50-year career in medicine. To track the information would require an estimated
18 quarter million dollar change to the membership accounting system.

19 20 CONCLUSION

21
22 While the composition of the House is the province of the HOD, your Board maintains that the
23 long-standing policy of counting actual members for apportionment, including a one-year grace
24 period for societies at risk of losing a delegate seat, has served our association, the House, and
25 members well. There is no clear evidence that counting pending members increases membership or
26 provides benefit to constituent societies. Counting pending members can be considered to diminish
27 or discount actual members' value as much as it can be seen to enhance representation. In addition,
28 it unnecessarily complicates the apportionment process and adds additional cost of tracking
29 pending members over time. Your Board concludes that the trial of counting pending members for
30 apportionment purposes should not be continued.

31
32 The adoption of the Policy G-600.959 [1] and the bylaw amendment from CC&B Report 1-I-22
33 specified the process that was followed for apportionment for 2023. The amended Bylaw
34 §2.1.1 includes a sunset provision for the entirety of the bylaw as of December 31, 2023. Given
35 that the apportionment process for 2023 is complete, Policy G-600.959 [1] should be rescinded as it
36 has been accomplished.

37 38 RECOMMENDATION

39
40 Therefore, your Board of Trustees recommends that paragraphs 2-4 of Policy G-600.016 and
41 paragraph 1 of Policy G-600.959 be rescinded and the remainder of the report filed.

Fiscal Note: \$150 to update PolicyFinder

RELEVANT AMA POLICY

Data Used to Apportion Delegates G-600.016

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

Delegate Apportionment and Pending Members G-600.959

1. Delegates will be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
 - The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
 - The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
 - For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates, apportioned at the rate of 1 per 1000, or fraction thereof, AMA members, plus 5.
 2. Pending members will no longer be counted for delegate apportionment.
- BOT Rep. 20, A-22; BOT Action in response to referred for decision: BOT Rep. 20, A-22

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-23

Subject: Making AMA Meetings Accessible

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 Policy G-630.140 [8], adopted by the American Medical Association House of Delegates (HOD) at
2 the 2022 Annual Meeting, called for a report to the HOD by no later than the 2023 Annual Meeting
3 with a plan on how to maximize meeting participation for members and invited attendees with
4 disabilities. This report responds to G-630.140 [8].

5 6 BACKGROUND

7
8 AMA meeting venues are selected several years in advance to secure locations and begin meeting
9 planning. Among the other considerations, management is directed by current AMA policy to
10 choose hotels for its meetings, conferences, and conventions based on size, service, location, cost,
11 and similar factors. For our Interim and Annual Meetings, efforts are made to locate the Section
12 Assembly Meetings in the House of Delegates meeting hotel or in a hotel in proximity.

13
14 When planning an event, it is important to consider accessibility for individuals with disabilities,
15 and AMA management takes this responsibility seriously by researching venues and assessing their
16 accessibility features, considering unique needs, and providing necessary aids for optimal
17 participation.

18
19 To ensure accessibility for individuals with disabilities, AMA management follows a thorough
20 process. This includes researching venues that have necessary accessibility features and conducting
21 in-person site visits to assess various features such as parking, entrances, elevators, ramps,
22 restrooms, all gender restrooms, seating arrangements, and audiovisual capabilities. Additionally,
23 AMA management considers unique needs such as sensory processing issues and provides options
24 for individuals to retreat to quiet spaces as needed. To further enhance participation, AMA
25 management offers various audio and visual aids to accommodate those who are sight or hearing
26 impaired. For individuals with hearing impairments, options include sign language interpreters,
27 assistive listening devices, and captioning. For individuals with visual impairments, options include
28 audio descriptions, tactile maps and models, Braille and large-print materials, and accessible
29 technology such as screen readers or magnification software.

30
31 For the hearing assistance device, management will work to ensure that the device is available and
32 working properly during management meetings. Members who require this device can inform
33 management in advance, and staff will make sure that the device is set up and ready for use. This
34 information will be included in the registration form for the meeting, or members can contact
35 management directly to request the device.
36

1 For an in-person interpreter, management will work to ensure that a qualified interpreter is
2 available for members who require this service. The cost of the interpreter will be covered by the
3 AMA, not by the member. Meeting services will coordinate with the interpreter and the member to
4 ensure that the interpreter is available at the appropriate time and location. Members who require
5 an interpreter can inform management in advance, and staff will make sure that an interpreter is
6 available.

7
8 For members in wheelchairs, management will work to ensure that the meeting venue is accessible
9 and that accommodations are made as needed. This may include providing accessible seating,
10 ensuring that there are accessible paths of travel throughout the venue, and making sure that any
11 equipment or materials needed by the member are available and accessible. Members who require
12 accommodations for mobility issues can inform management in advance, and staff will work with
13 the member to ensure that their needs are met.

14
15 Overall, management is committed to ensuring that all members are able to participate fully in
16 meetings and that their needs are accommodated appropriately. Members who require special
17 accommodations should inform management in advance, and staff will work to ensure that these
18 accommodations are made.

19
20 Further, the House of Delegates (HOD) Affairs Office provides an opportunity for delegates and
21 alternate delegates to request special accommodations thru the delegate credentialing process. Any
22 requests are handled by the Director, HOD Affairs, in conjunction with meeting services. The HOD
23 Office has been made aware of three instances where accommodations were needed. In those
24 instances, the attendees provided their own accommodations and informed the HOD Office for
25 awareness purposes.

1 CONCLUSION

2

3 Ensuring accessibility for all attendees, including those with disabilities, is an important aspect of
4 event planning and management. Providing accommodations such as assistive technologies and
5 sign language interpreters can help ensure that all attendees have an equal opportunity to
6 participate fully in the conference and benefit from its content. It is also important to ensure that
7 the accommodations are communicated clearly to attendees, so they know how to request them if
8 needed. By taking these steps, the conference organizers are demonstrating their commitment to
9 inclusion and creating a welcoming environment for all attendees.

10

11 AMA management considers that all the venues for the conference have taken steps to ensure that
12 they are compliant with the Americans with Disabilities Act (ADA) requirements. This means that
13 attendees with disabilities will have access to all areas of the venue, including entrances, restrooms,
14 and meeting rooms.

15

16 RECOMMENDATION

17

18 The Board of Trustees recommends that Policy G-630.140 [8] be rescinded as being accomplished
19 by this report, and the remainder of the report be filed.

Fiscal Note: No significant fiscal impact

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-23

Subject: Surveillance Management System for Organized Medicine Policies and Reports
(Resolution 609-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 Resolution 609 A-22 “Surveillance Management System for Organized Medicine Policies and
2 Reports,” sponsored by Georgia Delegation, was referred to the Board of Trustees. Resolution 609
3 A-22 asked:

- 4
- 5 1. That our American Medical Association develop a prioritization matrix across both global
6 and reference committee specific areas of interest (Directive to Take Action);
- 7 2. That our AMA develop a web-based surveillance management system, with pre-defined
8 primary and/or secondary metrics, for resolutions and reports passed by their respective
9 governance body (Directive to Take Action);
- 10 3. That our AMA share previously approved metrics and results from the surveillance
11 management system at intervals deemed most appropriate to the state and local
12 membership of organized medicine, including where and when appropriate to their
13 patients. (Directive to Take Action)
- 14

15 BACKGROUND

16
17 Resolution 609 describes a need to have appropriate surveillance and dissemination system(s) in
18 place that addresses the informational needs of physicians at the state and local levels including
19 those who are members of House of Delegates within organized medicine. Further, the resolution
20 asks that a prioritization matrix be created to aid delegates’ and Federation societies’ decision-
21 making in submission of relevant and timely resolutions.

22 *The role of prioritization matrices*

23
24
25 Decision-making and prioritization frameworks are in common use across industries. Prioritization
26 can be determined by any number of factors, but typical examples may include:

- 27 • Importance
- 28 • Urgency
- 29 • Relevancy
- 30 • Probability of Successful Outcome
- 31 • Risk
- 32

33 Matrices are used when executive decision-making is required to move forward. Typically, scoring
34 values (e.g. Rank-Order, Likert Scales) must be captured in a consistent manner. Furthermore, the
35 relative weighting of each factor is another important design element that must be determined.
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Current resources within AMA

By nature of our AMA’s councils, sections, and delegates structures, resolutions are shaped through a rigorous process of research, proposal, discussion, review and ultimately debate and voting.

Members of our House of Delegates today have access to a detailed House of Delegates microsite within *ama-assn.org*. The site provides a preliminary agenda that incorporates a “Bookmark” feature to allow delegates to be notified of changes over time.

There are three primary database tools available to the public:



AMA’s [PolicyFinder](#) resource allows delegates and other interested parties to search prior AMA policies with free text and Boolean keyword search. Information from this search includes Topic, Meeting Type, Action, Council & Committees, Year Last Modified, and Type. In addition to a description of the policy, there is a timeline that shows the trajectory of that policy, including relevant hyperlinks to council reports where possible (see Figure).

AMA’s [Council Report Finder](#) contains 347 artifacts as of February 2023. Users may search based on keywords and filter by meeting date and by Councils and Committees among others.

AMA [Archives](#) contains digests of official actions, historical monographs, HoD proceedings, and Transactions (records of day-to-day activities). As of this writing, the database houses materials from 1847 to 2019.

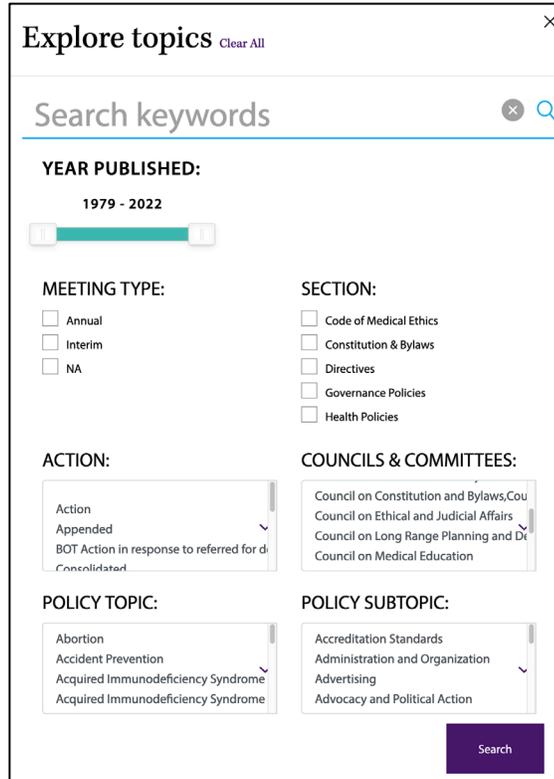
 A screenshot of a web page from the AMA PolicyFinder. At the top, the word "hypertension" is displayed in a blue font. To its right are a close button (X) and a search icon (magnifying glass). Below this is a purple banner with the text "Preventive Medicine" in white. Underneath the banner, the title "Medical Evaluations of Healthy Persons H-425.994" is shown. A table of metadata follows:

Topic: Preventive Medicine	Policy Subtopic: NA
Meeting Type: Interim	Year Last Modified: 2017
Action: Reaffirmed	Type: Health Policies
Council & Committees: NA	

 To the right of the table are icons for email, print, and download. Below the table is a paragraph of text starting with "The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease...". At the bottom, a "Policy Timeline" section shows a horizontal line with five blue dots representing different legislative actions: "CSA Rep. D, A-82", "Reaffirmed: CLRPD Rep. A, I-92", "Reaffirmed: CSA Rep. 8, A-03", "Reaffirmed: CSAPH Rep. 1, A-13", and "Reaffirmed: CMS Rep. 03, I-17".

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In addition to keyword searches, users can enable a variety of filters and flags to explore AMA policy. The screenshot below highlights some of these options:



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Prior organizational investments in House of Delegates usability

9 Our AMA maintains a website [repository of proceedings](#), accessible to the public, from prior
10 House of Delegates meetings, covering the prior decade. Visitors to this site can determine the
11 implementation status of reports and resolutions. Materials are available in PDF format and
12 searchable. Meetings dating prior to 2012 are located on AMA’s [archive database](#), also available to
13 members, the research community, and public.

14
15
16 In late 2022, AMA’s Strategic Insights team was asked to lead a user experience study on our
17 PolicyFinder. Study subjects specifically incorporated members of our HOD, Council, and
18 Reference Committee staff. The goals of the study were to better understand:

- 19 • The extent to which the design and functionality of PolicyFinder align with the needs and
20 expectations of target users (with particular attention to the search functionality)
- 21 • Usability issues that may impact the user experience and highlight opportunities for further
22 enhancement

23
24 This project is concluding at the time of this writing. The conclusions will be used to inform the
25 product development roadmap for PolicyFinder.

26
27 Significant financial and logistical challenges exist to maintain a prioritization matrix tool for use
28 by delegates. Any new tool deployment would require rigorous market and user research, product

1 development roadmaps, and significant data exchange infrastructure among states and specialties
2 that do not exist today. We anticipate there would be a high degree of manual data entry and
3 monitoring for changes that would require dedicated staff members. Additionally, a multi-
4 organization governance mechanism would need to be established that describes the prioritization
5 dimensions. We believe this would be a significant cost burden among AMA and the Federation,
6 without adding great value for the AMA, delegates, and societies.

7
8 *Federation Activities*

9
10 The experience of accessing policy and council reports from our Federation ranges widely. State
11 and specialty societies' resources and capabilities devoted to policy databases and reporting
12 systems are unknown but likely vary widely.

13
14 We reviewed options for three state medical societies. One society has testimony, letters, and
15 advocacy content available to the public, but the reports of its councils are not publicly available.
16 Another state medical society provided a downloadable Policy Compendium from their House of
17 Delegates but the link was broken. Another state medical association did not have a similar option.

18
19 One large specialty society provided a functional public database to browse Guidelines, Expert
20 Consensus Statements, Policy Documents, and artifacts. Another specialty examined did not have
21 any discernable publicly available database or archive of materials from their annual meeting.

22
23 RECOMMENDATION

24
25 In view of these considerations, your AMA recommends that the following recommendations be
26 adopted in lieu of Resolution 609-A-22 and that the remainder of this report be filed:

- 27
28 1. That our American Medical Association (AMA) maintains the existing resolution management
29 structure within the House of Delegates without imposing a potentially confusing or
30 unsustainable prioritization matrix on delegates and reference committees. (New HOD Policy)
31
32 2. That our AMA continues to invest in critical information technology and other appropriate
33 infrastructure that allows for the tracking of past resolutions, existing policy, and supporting
34 materials. (New HOD Policy)

35
Fiscal note:

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

Compensation Committee Report, June 2023

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

Presented by: Ray C. Hsiao, MD, Chair

Referred to: Reference Committee F

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This report by the committee at the 2023 Annual meeting presents one recommendation.

BACKGROUND

The Committee has commissioned its external consultant, Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, to conduct a comprehensive compensation review of Officer Compensation because it has been five years since the last review. The Committee intends to present the results of this review and related recommendations, if any, to the House at I-2023.

The Committee thanks our Officers for their representation of the AMA and recommends no changes to Officer Compensation pending completion of the comprehensive review.

RECOMMENDATION

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2023 through June 30, 2024. (Directive to Take Action.)
2. That the remainder of the report be filed.

Fiscal Note: \$0

APPENDIX

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

Definition of Governance Honorarium Effective July 1, 2017:

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

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

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

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

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

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

CCB/CLRPD Report 1-A-23

Subject: Joint Council Sunset Review of 2013 House Policies

Presented by: Kevin C. Reilly, Sr., MD, Chair, Council on Constitution and Bylaws
Edmond Cabbabe, MD, Chair, Council on Long Range Planning and
Development

Referred to: Reference Committee F

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

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

11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the House identifying policies
16 that are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-
19 600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so
20 long as the proposed changes are transparent to the House and do not change the meaning); (e)
21 For each recommendation that it makes to retain a policy in any fashion, the reviewing council
22 shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way
23 for the House to handle the sunset reports.
24

25 3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy
26 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
27 current policy, or has been accomplished.
28

29 4. The AMA councils and the House should conform to the following guidelines for sunset: (a)
30 when a policy is no longer relevant or necessary; (b) when a policy or directive has been
31 accomplished; or (c) when the policy or directive is part of an established AMA practice that
32 is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
33 House of Delegates Reference Manual: Procedures, Policies and Practices.
34

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

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

2

3 RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-405.991	Clarification of the Title "Doctor" in the Hospital Environment	<p>1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.</p> <p>2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.</p> <p>3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.</p>	<p>Retain. Still Relevant. [The Councils acknowledge there is some overlap with other AMA policies D-405.974, Clarification of Healthcare Physician Identification: Consumer Truth & Transparency, H-405.989, Physicians and Surgeons, and H-405.951, Definition and Use of the Term Physician, and H-405.969, Definition of a Physician, and plans to issue a consolidation report at I-23.]</p>
D-450.965	Patients' Responsibilities for Health Care Outcomes	<p>Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for</p>	<p>Sunset. Superseded by more recent policies that exist, including H-373.993, Medication Adherence, H-</p>

		<p>physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence.</p>	<p>450.942, Patient Adherence to Treatment Plans, H-115.967, Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts, H-275.976, Boundaries of Practice for Health Professionals, H-120.967, Dispensing of Drug Information, and Code of Medical Ethics Opinion 1.1.4, Patient Responsibilities.</p> <p>Improving Health Outcomes is one of AMA’s major focus areas. Other resources include The AMA’s STEPS Forward™ practice management tools which include modules on patient adherence, BOT Report 3-I-12, Physician Education to Support Patient Adherence to Treatment, and BOT Report 11-A-14, Medication Non-Adherence and Error.</p>
<p>D-75.994</p>	<p>Tubal Ligation and Vasectomy Consents</p>	<p>1. Our AMA will work closely with the American College of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure. 2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.</p>	<p>Sunset. Superseded by more current policy H-290.977, Medicaid Sterilization Services Without Time Constraints. Also, BOT 17-A-14, Tubal Ligation and Vasectomy Consents provides a historical context to the issue.</p>
<p>G-600.045</p>	<p>Online Member Forums in the House of Delegates</p>	<p>Online member forums should be incorporated into every House of Delegates policymaking meeting, using the following parameters: a. Each reference committee should participate in the online member</p>	<p>Retain. Still relevant. Policy D-600.956, Increasing the Effectiveness of</p>

		<p>forum process; b. Each online member forum should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook; c. Comments submitted to an online member forum should be used to prepare a summary report that reflects the comments received up to that point; d. Full, free and complete testimony should be allowed in the onsite hearings; and e. The Speakers should experiment with alternative procedures to enhance and improve the overall online member forum process.</p>	<p>Online Reference Committee, commits our AMA to a two-year study of preliminary reference committee documents based on the written online testimony, with those documents being used to inform the discussion at the in-person reference committee.</p>
<p>G-615.001</p>	<p>Establishment and Function of Sections</p>	<p>1. Our AMA adopts the following criteria in consideration of requests for establishing new sections or changing the status of member component groups:</p> <p>A. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.</p> <p>B. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.</p> <p>C. Appropriateness - The structure of the group will be consistent with its objectives and activities.</p> <p>D. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate.</p> <p>E. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.</p> <p>F. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.</p> <p>2. Our AMA will consider requests for establishing new sections by letter of application to the CLRPD, which will make recommendations to the</p>	<p>Retain. Still relevant and necessary to specify the criteria used to evaluate new sections or changing the status of a member component group. A five-year review cycle of delineated sections provides an excellent opportunity for the House to receive updates on section activities to ensure that these sections continue to meet HOD goals.</p> <p>CLRPD Report 1-I-10, Establishment and Function of Sections provides a historical context.</p>

		<p>BOT and HOD for further action or by submission of a resolution.</p>	
<p>G-625.020</p>	<p>AMA Strategic Planning</p>	<p>1. Our AMA annual strategic planning cycle shall include the following dimensions: (a) Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process. (b) Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan.</p> <p>2. Our AMA strategic planning process should generate: (a) A multi-year plan that identifies the most critical strategic issues for the organization; (b) The critical success factors for each issue; and (c) Annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes.</p> <p>3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan.</p> <p>4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified.</p> <p>5. The AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way.</p> <p>6. Our AMA Board of Trustees will continue to (a) consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions; (b) exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities; and (c) monitor the activity and results related to commitments established in the planning process.</p>	<p>Retain as editorially amended in #7 for accuracy. Still Relevant and Necessary.</p>

		7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician Action-Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.	
H-255.967	Mock Residency Interview Program	Our AMA will promote the AMA-International Medical Graduates Section's Mock Residency Interview Program to any AMA member who is in the process of applying for a medical residency position and as one of the benefits of AMA membership.	Retain. Still Relevant and Necessary
H-40.993	Support of the Civilian-Military Contingency Hospital System	The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict.	Retain. Still Relevant.
H-475.992	Definitions of "Cosmetic" and "Reconstructive" Surgery	(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.	Retain. Still Relevant.
H-475.983	Definition of Surgery	Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11: Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks	Retain. Still Relevant.

		<p>of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.</p> <p>Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.</p>	
H-475.988	Laser Surgery	The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery.	Rescind (duplicative of Policy H-475.983 being recommended for retention).
H-475.984	Office-Based Surgery Regulation	<p>Our AMA supports the following Core Principles on Office-Based Surgery: Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013). Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system http://www.asahq.org/for-members/clinical-information/asa-physical-status-classification-system.aspx. Accessed July 2, 2013). Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified. Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with</p>	Retain as editorially amended for accuracy. Still relevant.

		<p>another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital. Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. Med. Licensure Discipline. 2002; 88: 160-174). Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. Journal Medical Licensure and Discipline. 2002; 88:160-174). Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care. Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards. Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS). Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.</p>	
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<p>D-478.977</p>	<p>Exam Room Computing and Patient Physician Interactions</p>	<p>Our AMA will make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles, and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.</p>	<p>Sunset. The actions requested have been accomplished. The AMA's STEPS ForwardTM practice management tools, found at the AMA Ed HubTM, provide physicians with in-depth CME on acquisition and efficient use of an EHR. Modules include "Electronic Health Record (EHR) Software Selection and Purchase" and "Electronic Health Record Optimization: Strategies for Thriving," which include techniques physicians and office staff can use to "maximize the benefits and minimize the burdens of the EHR." The AMA Ed Hub also includes a substantial selection of EHR case studies. An additional resource is AMA's Taming the EHR Playbook. Policy, H-480.971, commits our AMA to continued work in this area.</p>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-23)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

1 Whereas, Some physicians are turned off by third-party solicitation material mailed with the
2 American Medical Association brand, such as regarding disability insurance or student loan
3 refinancing, potentially harming the AMA's reputation and costing physician membership; and
4

5 Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA
6 branded third-party disability insurance plan¹; and
7

8 Whereas, There is a financial and environmental cost to printed solicitation; and
9

10 Whereas, Associating the AMA brand to specific third-party products may or may not be in the
11 best interest of the AMA or current and potential AMA members; therefore be it
12

13 RESOLVED, That our American Medical Association study the use of AMA branded solicitation
14 material mailed to physicians, the impact it has on the perception of our AMA by current and
15 potential physician members, and the merits of continuing to use these materials in future
16 communications (Directive to Take Action); and be it further
17

18 RESOLVED, That our American Medical Association survey our membership on the preferred
19 method to receive third-party solicitation material (mail, phone, email, social media) and provide
20 a method to opt-out of certain methods if not desired. (Directive to Take Action)

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

Received: 3/19/23

REFERENCES

1. [AMA's Disability Insurance: You Get What You Pay For - White Coat Investor](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-23)

Introduced by: Medical Student Section

Subject: Supporting the Use of Gender-Neutral Language

Referred to: Reference Committee F

1 Whereas, Existing American Medical Association policy inconsistently uses gendered language-
2 in particular, gender pronouns- when referring to physicians, medical students, patients, and
3 others, most often referencing generic individuals with traditionally male and sometimes female
4 pronouns (“he/him/his”, “he or she”, “his or hers”); and
5

6 Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states
7 “Our AMA believes that the primary mission of the physician is to use his best efforts and skill in
8 the care of his patients...”; and
9

10 Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current
11 U.S. medical students are women, and there many medical students and physicians who have
12 other genders that are not male or female, including gender-expansive, gender-fluid, gender-
13 nonconforming, genderqueer, nonbinary, and others^{1,2,7}; and
14

15 Whereas, The frequent default use of male pronouns to describe generic physicians in AMA
16 policy (for example, using “him” and “his” as pronouns for “the physician”) may reinforce
17 patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such
18 pronouns³⁻⁶; and
19

20 Whereas, Gender identity exists on a spectrum that includes cisgender individuals whose
21 gender identity aligns with their sex assigned at birth and transgender individuals whose gender
22 identity differs from their sex assigned at birth⁸; and
23

24 Whereas, Cisnormative, gender-specific language has been shown to contribute to health
25 disparities and alienate gender-diverse people from accessing care⁹⁻¹²; and
26

27 Whereas, The use of cisnormative, gender-specific language in public health campaigns such
28 as breast cancer screening, testicular cancer awareness, HPV vaccination, and dissemination
29 of PrEP has contributed to health disparities that negatively impact gender-diverse patients¹³⁻¹⁵;
30 and
31

32 Whereas, Cisgendered imagery in medical education including anatomical diagrams has been
33 demonstrated to exacerbate gender bias in students and contribute to students’ reduced
34 comfort and knowledge in treating gender-diverse patients¹⁶⁻¹⁷; and
35

36 Whereas, Reputable organizations and government departments that guide the public via public
37 health communication continue to use gendered messaging that excludes gender-diverse
38 individuals; for example, alcoholic beverage warning labels that read “*women* should not drink
39 alcoholic beverages during pregnancy because of the risk of birth defects”¹⁸; and

1 Whereas, The use of gendered messaging in spaces such as Women’s Health Clinics with pink
2 chairs, patient restrooms labeled as a “women’s” restrooms, and brochures containing language
3 helpful for cisgender women only, have been shown to be stigmatizing and isolating for gender-
4 diverse individuals and may discourage them from accessing necessary services¹⁹; and

5
6 Whereas, Gender-neutral language has been shown to positively impact the comfort and
7 psychological safety of gender-diverse individuals “in the institutions with which they must
8 interact”²⁰; and

9
10 Whereas, To address the exclusion of gender-diverse individuals through the use of gendered
11 messaging, peer organizations are already adopting gender-neutral language, including the
12 Section on Women’s Health of the American Physical Therapy Association which changed its
13 name to the Academy of Pelvic Health Physical Therapy and the American College of
14 Obstetricians and Gynecologists which released Committee Opinion 823 recognizing that not all
15 pregnant individuals may identify as “mothers”²¹⁻²²; and

16
17 Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing
18 that American physicians and the patients we serve have diverse gender identities and may use
19 similarly diverse personal pronouns; and

20
21 Whereas, One solution for correcting the bias established by using traditionally male pronouns
22 as default in AMA policy is to replace them with gender-neutral pronouns such as “they”, “them”,
23 “their”, and “theirs”, which are pronouns used by many gender non-binary individuals and may
24 also be used to collectively describe people of all genders⁷; and

25
26 Whereas, The pronouns “they”, “them”, “their”, and “theirs” have long been widely accepted as
27 both singular and plural pronouns, allowing them to be incorporated into AMA policy with great
28 flexibility²³⁻²⁵; and

29
30 Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into
31 AMA policy would be an efficient and adequate way to collectively reference medical students,
32 physicians, patients, and others of all genders; and

33
34 Whereas, Updating the language in our AMA’s policies to be maximally inclusive is a simple act
35 that aligns with our organization’s work to document and appreciate the diversity in sexual
36 orientation and gender identity (SOGI) of our members as well as to champion gender equity
37 and non-discrimination in medicine and society²⁶⁻³¹; and

38
39 Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future
40 language relating to LGBTQ people, establishes precedent for this timely action; therefore be it

41
42 RESOLVED, That our American Medical Association (1) Recognize the importance of using
43 gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in
44 respecting the spectrum of gender identity, (2) revise all relevant policies to utilize gender-
45 neutral language in place of gendered language where such text inappropriately appears, (3)
46 utilize gender-neutral language in future policies, internal communications, and external
47 communications where gendered language does not specifically need to be used, (4)
48 encourage the use of gender-neutral language in public health and medical messaging, (5)
49 encourage other professional societies to utilize gender-neutral language in their work, and (6)
50 support the use of gender-neutral language in clinical spaces that may serve both cisgender
51 and gender-diverse individuals. (New HOD Policy)

Fiscal Note: Up to \$23K to review all current AMA policies and compile a report with recommendations for HOD consideration

Received: 3/24/23

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RELEVANT AMA POLICY

Professionalism in Medicine H-140.951

Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.

Citation: Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09; Consolidated: CEJA Rep. 03, A-19;

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21;

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Citation: BOT Rep. 27, A-19;

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974

Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, to our membership.

Citation: Res. 014, A-18;

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Utilization of "LGBTQ" in Relevant Past and Future AMA Policies D-65.990

Our AMA will: (1) utilize the terminology lesbian, gay, bisexual, transgender, and queer and the abbreviation LGBTQ in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation LGBTQ in place of the abbreviations LGBT and GLBT where such text appears; and (3) revise all relevant and active policies to utilize the terms lesbian, gay, bisexual, transgender, and queer to replace lesbian, gay, bisexual, and transgender where such text appears.

Citation: Res. 016, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Sustainability of AMA National Meetings

Referred to: Reference Committee F

1 Whereas, The World Health Organization (WHO) and our AMA have called climate change
2 “the greatest public health challenge of the 21st century”^{1,2}; and
3

4 Whereas, Reputable entities including the WHO, Intergovernmental Panel on Climate
5 Change (IPCC), and U.S. Global Change Research Program assert that climate change has
6 had an effect on, and continues to pose a great risk for, human health through climate related
7 extreme weather events, worsening air quality, and increased disease transmission^{1,3,4}; and
8

9 Whereas, Climate change is primarily driven through human activity and the release of
10 greenhouse gases, including carbon dioxide, into the atmosphere⁵; and
11

12 Whereas, The United States healthcare system alone is responsible for 10% of national
13 greenhouse gas emissions and, if it were its own country, it would be the 13th largest
14 producer of greenhouse gas emissions in the world^{6,7}; and
15

16 Whereas, Extreme weather and climate events have significantly increased healthcare
17 spending in the United States, with \$14 billion in additional spending through 760,000
18 additional patient encounters and 1,689 premature deaths between 2000 and 2009^{8,9}; and
19

20 Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is
21 possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme
22 measures are taken to curtail anthropogenic emissions¹⁰; and
23

24 Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207
25 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe
26 heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100¹⁰;
27 and
28

29 Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in
30 ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases
31 in the United States by 2100^{8,9}; and
32

33 Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require “global
34 net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels
35 by 2030, and reach net zero by approximately 2050”¹⁰; and
36

37 Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of
38 greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific
39 time period⁸; and

1 Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-
2 profit organizations, large corporations, and countries have committed to carbon neutrality for
3 their business operations by a date certain in order to improve their business efficiencies and
4 to foster the development of carbon neutral practices¹¹⁻¹³; and
5

6 Whereas, Multiple organizations in the healthcare industry have committed to becoming
7 carbon neutral on or before 2030, including Harvard Medical School and its affiliated
8 hospitals, all University of California campus and medical centers, the Cleveland Clinic, and
9 Kaiser-Permanente¹⁴⁻¹⁷; and
10

11 Whereas, Other professional organizations, including the Association of Energy Services
12 Professionals, and International Federation of Medical Students' Associations have
13 committed to making their conferences carbon neutral^{18,19}; and
14

15 Whereas, Our American Medical Association has set discrete benchmark dates for achieving
16 goals in other settings, including child blood lead levels (H-60.924), accreditation of health
17 care service providers in jails (D-430.997), and disaggregation of demographic data (H-
18 350.954); and
19

20 Whereas, Our AMA has substantial policy recognizing the impacts of climate change,
21 committing to sustainable business operations, emphasizing the importance of physician
22 leadership regarding climate change, encouraging the study of environmental causes of
23 disease, and encouraging other stakeholders in healthcare to practice environmental
24 responsibility, but has no explicit emissions goal and no way to account for progress towards
25 environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973);
26 therefore be it
27

28 RESOLVED, That our American Medical Association commit to reaching net zero emissions
29 for its business operations by 2030, and remain net zero or net negative, as defined by a
30 carbon neutral certifying organization, and report annually on the AMA's progress towards
31 implementation (New HOD Policy); and be it further
32

33 RESOLVED, That our AMA work with appropriate stakeholders to encourage the United
34 States healthcare system, including but not limited to hospitals, clinics, ambulatory care
35 centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030
36 and become net zero by 2050, and remain net zero or negative, as defined by a carbon
37 neutral certifying organization, including by creating educational materials (Directive to Take
38 Action); and be it further
39

40 RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for members
41 traveling to and from Annual and Interim meetings and report back to the House of Delegates
42 (Directive to Take Action); and be it further
43

44 RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim
45 meetings at Leadership in Energy and Environmental Design-certified or sustainable
46 conference centers and report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: It is currently impossible to provide more precise cost information given the myriad factors involved.”

Received: 4/5/23

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

- Our AMA:
1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
 2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
 4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for

promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16; Reaffirmation: I-19;

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;

(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to

work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.

Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22;

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

2. Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable.

Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22;

EPA and Green House Gas Regulation H-135.934

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.

2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17;

Conservation, Recycling and Other "Green" Initiatives G-630.100

AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.

Citation: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22;

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17; Appended: Res. 403, A-19;

Reducing Lead Poisoning H-60.924

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 g/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 g/dL (10 ppb).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 g/dL (10 ppb).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17;

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

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

Environmental Health Programs H-135.969

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Federal Programs H-135.999

The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

Citation: BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-23)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Speakers Task Force to Review and Modernize the Resolution Process

Referred to: Reference Committee F

1 Whereas, Our American Medical Association House of Delegates recently reviewed and revised
2 the election process for officers and councils through a Speakers Task Force; and
3

4 Whereas, The process of submitting, reviewing, evaluating, reporting, and voting on resolutions
5 in our HOD has not changed in many years; and
6

7 Whereas, For the past two years, all delegations and sections have met virtually and have been
8 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA
9 HOD; and
10

11 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each
12 year; and
13

14 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and
15 vetted by all delegations and delegation staff and reference committee members prior to the
16 start of the reference committee hearings; and
17

18 Whereas, According to Bylaws 2.11.3.1.3, "Late resolutions may be presented by a delegate
19 prior to the recess of the opening session of the House of Delegates, and will be accepted as
20 business of the House of Delegates only upon two-thirds vote of delegates present and voting";
21 and
22

23 Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, "resolutions of an
24 emergency nature may be presented by a delegate any time after the opening session of the
25 House of Delegates is recessed. Emergency resolutions will be accepted as business only upon
26 a three-fourths vote of delegates present and voting, and if accepted shall be presented to the
27 House of Delegates without consideration by a reference committee. A simple majority vote of
28 the delegates present, and voting shall be required for adoption"; and
29

30 Whereas, The ability to meet virtually and work asynchronously was enhanced during the
31 pandemic to the point where it is potentially more efficient and convenient for Delegations and
32 Sections; therefore be it
33

34 RESOLVED, That our American Medical Association form a Speakers Task Force on the
35 Resolution Process to review the entire process of handling resolutions for our AMA House of
36 Delegates, including but not limited to definitions of on time resolutions, emergency resolutions,
37 and late resolutions, deadlines for submission of resolutions by all sections, processing and
38 review of reference committee reports, and use of virtual meetings so that all on time resolutions
39 can be submitted by the same deadline (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our
- 2 AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the
- 3 resolution process. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Procedure B-2.11

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-23)

Introduced by: International Medical Graduates Section

Subject: Equity and Justice Initiatives for International Medical Graduates

Referred to: Reference Committee F

1 Whereas, International medical graduates represent 25% of the physician workforce in the
2 United States and constitutes the backbone of the medical healthcare system in rural and
3 underserved areas; and
4

5 Whereas, International medical graduates continue to be treated with explicit and implicit biases
6 during their training, academic and community careers, careers in organized medicine, and
7 consideration for leadership positions as reported by recent studies; and
8

9 Whereas, The American Medical Association created the Center for Health Equity in 2019 which
10 released the health equity strategic plan in 2021, which lacks a specific strategy to address the
11 unique challenges faced by international medical graduates in achieving equity and justice in
12 their medical practice in the U.S.; therefore be it
13

14 RESOLVED, That our American Medical Association, via the Center for Health Equity, create a
15 yearly session (during the Interim or Annual Meeting) as a part of the equity forum that will be
16 dedicated to international medical graduates (Directive to Take Action); and be it further
17

18 RESOLVED, That our AMA, via the Center of Health Equity, create an amendment to the health
19 equity plan that will address the issues of equity and justice for international medical graduates.
20 (Directive to Take Action)

Fiscal Note: Approximately \$44K for a one-time update of the health equity strategic plan, plus
~\$24k annually to produce the requested forum.

Received: 4/27/23

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3. Professional challenges of non-US-born international graduates and recommendations for support during residency training. Nov 2011. Peggy Guey-Chi Chen et al. PMID: 21952056

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
 2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.
- Citation: BOT Rep. 33, A-18;

Reference Committee G

BOT Report(s)

- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2013 House Policies
- 05 Prescription Drug Dispensing Policies
- 08 Impact of Integration and Consolidation on Patients and Physicians
- 09 Federally Qualified Health Centers and Rural Health Care

Resolution(s)

- 701 Reconsideration of the Birthday Rule
- 702 Providing Reduced Parking for Patients
- 703 Tribal Health Program Electronic Health Record Modernization
- 704 Interrupted Patient Sleep
- 705 Aging and Dementia Friendly Health Systems
- 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
- 707 Expediting Repairs for Power and Manual Wheelchairs
- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures
- 709 Hospital Bans on Trial of Labor After Cesarean

REPORT 14 OF THE BOARD OF TRUSTEES (A-23)
Advocacy of Private Practice Options for Healthcare Operations in Large Corporations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting of the House of Delegates, Policy D-160.912, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations,” was adopted. The policy directs the American Medical Association to (1) study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal health care within Fortune 500 corporations in America with a report back at the 2023 Annual Meeting, (2) use proposals for the advocacy of small business medicine and private practice models in health care as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the health care service market with internalized models of health care in the complete absence of more diverse private practice (small business) options, and (3) prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the health care industry (Directive to Take Action).

To study potential pilots to advance the advocacy of private practice within corporate health care, the AMA conducted a market landscape assessment based on publicly available news articles and studies. Confidential informational interviews were undertaken among a small sample of national corporate entities with individuals directly responsible for each organization’s strategy in care delivery. These interviews were conducted with a series of pre-determined questions regarding their approaches and strategic thinking on care delivery and the role of private practices in the community. Three key themes emerged from this market analysis:

1. Corporate entities are increasingly investing in opportunities in care delivery and believe this strategy will increase value for their insured employees, their customers and shareholders.
2. Corporations believe “value-based” payment and delivery models will drive better patient outcomes and lower health care costs and are investing heavily in these models.
3. While acquisition of independent practices is accelerating in certain markets, some corporate entities, particularly among vertically integrated health insurers, have a strategy of working with independent practices in communities. These companies express a goal of supporting integrated networks of practices, with the aim of providing more enhanced, coordinated care for patients and preventing practice acquisition by larger health care systems or hospitals that can lead to consolidation and attendant price increases. Newer corporate retail and technology entrants will continue experimenting with various arrangements subject to market conditions and shareholder priorities.

Based on the market assessment, the AMA identified vital opportunities to (1) inform corporations about the value of private practices in successfully implementing new “value-based” models; (2) identify and work with a specific corporate entity advancing these models to explore a two-year pilot with independent private practices in which the AMA will: (a) convene practices in a community; (b) provide educational resources and technical assistance to practices to support participation in a pilot; and (c) formally evaluate the pilot for outcomes; and (3) continue advocacy that improves “value-based” models to ensure that physicians can succeed in these models with adequate payment, infrastructure and data.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-23

Subject: Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee G

1 INTRODUCTION

2
3 At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Policy D-160.912,
4 “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations.” This
5 policy directs our American Medical Association (AMA) to: (1) study the best method to create
6 pilot programs which advance the advocacy of private practice and small business medicine within
7 the rapidly growing area of internal healthcare within Fortune 500 corporations in America with a
8 report back at the 2023 Annual Meeting; (2) use proposals for the advocacy of small business
9 medicine and private practice models in healthcare as a pilot project in the development of
10 advocacy programs within major leading corporations like Amazon and Walmart which are
11 currently entering the healthcare service market with internalized models of healthcare in the
12 complete absence of more diverse private practice (small business) options, and (3) prioritize
13 advocacy efforts that emphasize small private practice utilization within the investment and
14 business efforts of Fortune 500 corporations that are currently seeking to enter into the healthcare
15 industry.

16
17 BACKGROUND:

18
19 Over the last two decades, large corporations have increasingly entered health care delivery—a
20 trend that has accelerated following the onset of the COVID-19 pandemic. These entities include
21 Walmart, CVS, Walgreens and Amazon, as well as national health insurance corporations such as
22 UnitedHealth Group. Even unexpected corporate retailers like Dollar General are offering health
23 care delivery models. These corporations have assumed various roles within health care, such as in-
24 person and virtual health care delivery, pharmaceuticals, wellness and employer-sponsored health
25 insurance.

26
27 Following blocked mergers of Aetna-Humana and Anthem-Cigna in 2017, these large national
28 insurers, along with United Healthcare, accelerated acquisitions of other types of health care
29 companies.¹ This represented a shift from horizontal integration (two health insurers merging) to
30 vertical integration (different parts of the health care delivery system merging). These acquisitions
31 and mergers include retail pharmacies (e.g., Aetna-CVS), pharmacy benefit managers (e.g., Cigna-
32 Express Scripts) and data/analytic companies (e.g., United-Change Healthcare). In addition, these
33 organizations are acquiring a broad spectrum of health care delivery organizations, from physician
34 practices to home health companies to mental health care companies. For example, UnitedHealth
35 Group's Optum Health is now the largest employer of physicians in the country.²

1 In addition to traditional health insurers, new entrants such as large retailers (e.g., Walmart) and
2 new and established technology companies (e.g., Amazon) are entering the health care delivery
3 space. These organizations are entering health care delivery as a new revenue source to drive
4 shareholder value, create synergy with other portions of their business (e.g., pharmacy) and help
5 control employee health care costs.^{3,4,5,6} While these investments have not been as expansive as the
6 large national health insurers, they will likely shake up health care delivery with new models of
7 pricing, the integration of technology and alignment with their other offerings.

8
9 The consumerization of health care is one factor that has fostered opportunities for corporations not
10 traditionally involved in health care delivery to enter these spaces and offer greater convenience at
11 a lower cost.³ Occurring alongside this trend is the acquisition of independent physician practices
12 by these large corporations, as well as by hospitals and payers. According to one estimate,
13 corporate entities acquired over 30,000 additional physician practices between 2019 and 2021.⁷ The
14 2020 AMA Physician Practice Benchmark survey found that less than half of patient care
15 physicians worked in private practice, nearly five percent lower than two years prior.⁸

16
17 Some see this trend of corporate entry into health care as positive, believing it will make health
18 care more sustainable and provide physicians greater access to capital, negotiating power and the
19 latest technology. However, others view it as disruptive to high-quality, coordinated care delivered
20 by a physician-led team, believing it decreases access and competition.⁸ There is also limited
21 scrutiny of the impact on market competition, as some proposed transactions involving the
22 corporate acquisition of physician practices may not come to the attention of antitrust enforcers if
23 the transaction is not sufficiently large enough to trigger statutory reporting obligations.⁹

24
25 Further, restrictive networks are commonly associated with these acquisitions. For instance,
26 patients receiving care from a physician employed by a hospital or large corporation may only
27 receive referrals to other clinicians employed by said hospital or corporation. This can lead to less
28 patient choice and arbitrary removal from networks of independent physicians.¹⁰ As these large
29 corporations continue their entry into the health care market, this can result in more harm than good
30 if the voices of patients and community-based private practice physicians are not integrated into
31 their plans.

32 33 *The Role of Large Corporations in Health Care: Recent Examples*

34 35 Amazon

36
37 Amazon's entry into health care predominantly consists of health care services, such as in-person
38 care, telehealth, and pharmaceuticals. For example, the company launched a telehealth service,
39 Amazon Care, after first piloting it to its employees.³ Designed to address high employee health
40 care costs, the app-based platform partnered with One Medical to offer members in-person and
41 virtual primary, urgent, and preventive care services, including COVID-19 and flu testing,
42 vaccinations, and treatment for illnesses and injuries.^{3,11} One Medical places medical offices near
43 the workplace, and its members use an app to book appointments and track health records.¹² The
44 platform reported a membership of 790,000 customers at the end of June 2022.¹³ In June 2022,
45 Amazon announced its intent to purchase OneMedical for \$3.9 billion.^{14,15} After an eight month
46 review, the Federal Trade Commission (FTC) declined to challenge the acquisition and the deal
47 was finalized on February 22, 2023.^{12,16}

1 CVS

2
3 Perhaps the most established in health care of the mentioned corporations, CVS, is focused on
4 journeying further into primary care.^{4,5} The company has offered walk-in health care services since
5 the early 2000s. Today, consumers may take advantage of routine physicals, screenings,
6 vaccinations, treatment for illnesses and minor injuries, mental health counseling and services that
7 address social determinants of health, such as wellness and health education classes, tobacco
8 cessation support and sleep assessments.⁴ In addition to the company’s 10,000 pharmacy locations,
9 CVS recently amassed a 10,000-clinician-network that makes in-person and virtual home visits
10 through its Signify Health acquisition.⁶

11
12 A key part of its strategy to deliver on its goal, announced in 2021, to facilitate 65 billion health
13 care interactions over the next decade, is to transform the number of stores converted to the
14 HealthHUB model. With over 20 percent of the store dedicated to these HealthHUBs, this concept
15 is designed to provide patients with chronic disease management consultations and other health and
16 wellness services such as sleep apnea assessments and blood draws. Further, the concept will offer
17 an array of durable medical equipment and other medical supplies¹⁷. As the HealthHUBs are
18 currently staffed by nurse practitioners, CVS aims to hire physicians to staff the primary care sites.
19 In addition to offering convenience to customers, the company also believes these efforts will
20 reduce health care costs.⁵

21
22 Most recently, CVS acquired Oak Street Health for \$10.6 billion. Oak Street’s centers
23 predominantly serve low- to middle-income patients aged 65 and older with Medicare Advantage
24 plans. The company operates in 169 locations throughout 21 states, and its locations are expected
25 to increase to 300 by 2026.¹⁸

26
27 Walmart

28
29 Walmart continues to disrupt the health care industry through low-cost health care services and
30 insurance.¹⁹ The company opened comprehensive health clinics in 2019 that offer affordable
31 services such as primary care, urgent care, dental care, mental health counseling, and vision and
32 hearing services.⁵ In addition to the 20 clinic locations that the company currently operates in
33 Georgia, Walmart has over 5,000 pharmacy locations and aims to expand to Florida in 2023.^{11,12}
34 Walmart now also offers virtual care through its telehealth platform, MeMD, and recently procured
35 an agreement with UnitedHealth Group, the world’s largest insurer.^{5,6} Through this partnership,
36 Walmart and UnitedHealth Group will offer a Medicare Advantage plan. UnitedHealth Group will
37 provide data analytics and decision support tools to Walmart clinicians, and Walmart Health’s
38 virtual care services will be included as part of one of UnitedHealth’s commercial PPO plans.⁴

39
40 Walgreens

41
42 Walgreens is also focused on offering health care services, as demonstrated by its recent launch of
43 Walgreens Health. The company currently owns 70 VillageMD primary care clinics. Walgreens
44 continues to provide in-store services such as health tests, screenings and help with medications.
45 The company also created an online marketplace where users may schedule appointments.⁵

46
47 Elevance Health

48
49 Elevance Health, formerly Anthem, combines care delivery tools and technology in its Carelon
50 Division with its health insurance companies, with aspirations of growing beyond providing health
51 insurance to become a “lifetime partner” in the delivery of healthcare to its members.²⁰ Unique

1 among other insurance companies that have purchased physician practices as part of their delivery
2 network, Elevance is investing in an “Aggregator Strategy.” Through this strategy, Carelon, with
3 other third-party partners, provides infrastructure and data analytics to independent primary care
4 physician practices to enable them to effectively participate in value-based contracts so they can
5 remain independent in local communities.^{20,21}

6 7 UnitedHealth Group

8
9 UnitedHealth Group is an example of a large vertically-integrated health care corporation that
10 comprises a health insurance company, UnitedHealthcare, a solutions service, Optum, and a
11 provider group subsidiary, Optum Health. Optum Health owns physician practices inclusive of
12 approximately 60,000 physicians who treat over 20 million patients annually. Much of this growth
13 is derived from the group’s focus on value-based care. Optum’s CEO, Andrew Witty, expects that
14 the company will have four million patients in accountable care arrangements in 2023.²¹ The
15 company plans to continue its expansion of value-based services—Witty informed investors that
16 Optum Health intends to integrate further behavioral and home health offerings into its health care
17 strategy.²³

18 19 Dollar General

20
21 In January 2023, Dollar General announced a partnership with DocGo, a publicly traded company
22 that offers “last-mile care” via mobile health care clinics with trained providers, a transportation
23 and logistics network, and an advanced data analytics network to deliver quick and easy health
24 visits outside Dollar General stores. DocGo onsite care is provided by certified medical assistants,
25 emergency medical technicians, licensed practical nurses, paramedics and physicians via remote
26 technology. Services offered at Dollar General locations will include preventive visits and chronic
27 care management. Dollar General, with over 18,000 stores nationwide—many in underserved rural
28 and urban areas—seeks to make health care more accessible and convenient for its shoppers.²⁴

29 30 Others

31
32 Other companies, including National Public Radio (NPR), CHG Healthcare Services, USAA,
33 Goldman Sachs, CustomInk, Anthrex, JM Family Enterprises and QuikTrip, have begun providing
34 their employees with on-site health care services. NPR’s and CHG’s health clinics are available at
35 no cost to all employees regardless of their enrollment status within the companies’ health plans.
36 USAA offers its employees cancer screenings, flu shots, blood pressure checks, massages and
37 physical rehabilitation. Goldman Sachs’ and QuikTrip’s health care benefits are available to all
38 enrolled employees and their families. Further, many physicians employed by QuikTrip work
39 exclusively for the company.²⁵

40 41 Investments and Support of Private Practices

42
43 Also accelerating is private sector investment in small- to medium-sized physician practices for the
44 purpose of providing infrastructure to transition to value-based models. There has been significant
45 growth in companies specifically designed to help independent practices succeed in value-based
46 models, including Aledade, Emergence Healthcare Group, Redesign Health and Privia.
47 Representing a shift from the 2010s, wherein founders of venture capital-backed health tech mainly
48 pursued large payers and employers, as well as hospitals, there has been recent interest in selling to
49 small- to medium-sized businesses which include private practices. Owners of private practices are
50 increasingly seeking to remain independent, and these opportunities provide them with the agency

1 and revenue to do so.²⁶ Private equity firms see significant opportunities in investing in physician
2 practices across specialties to offer administrative support.²⁷

3
4 *AMA Market Analysis*

5
6 The AMA conducted confidential informational interviews to better understand the evolving
7 market landscape and identify opportunities to create pilot programs to advance the advocacy of
8 private practice and small business medicine within the rapidly growing area of health care
9 delivery within Fortune 500 corporations in America.

10
11 To better understand the best method to explore the creation of potential pilots, the AMA: (1)
12 conducted (1) a market landscape assessment based on publicly available news articles and studies;
13 and (2) qualitative informational interviews among a sample of national corporate entities. The
14 confidential informational interviews were conducted between Fall 2022 and Winter 2023 with
15 individuals directly responsible for each organization’s strategy in health care delivery. The
16 interviews were conducted with a series of pre-determined questions regarding corporate entities’
17 approaches and strategic thinking on health care delivery and the role of private practices in the
18 community. Interviews included a selection of large national insurers vertically integrating into the
19 delivery of care through acquisitions, along with national retailers and large technology companies
20 entering the health care delivery marketplace.

21
22 Three key themes emerged from this market analysis:

- 23
24 1. Corporate entities are increasingly investing in opportunities in care delivery and believe
25 this strategy will increase value for their insured employees, their customers and
26 shareholders.
27 2. Corporations believe “value-based” payment and delivery models will drive better patient
28 outcomes and lower health care costs and are investing heavily in these models.
29 3. While acquisition of independent practices is accelerating in certain markets, some
30 corporate entities, particularly among vertically integrated health insurers, have a strategy
31 of working with independent practices in communities. These companies express a goal of
32 supporting integrated networks of practices, with the aim of providing more enhanced,
33 coordinated care for patients and preventing practice acquisition by larger health care
34 systems or hospitals that can lead to consolidation and attendant price increases. Newer
35 corporate retail and technology entrants will continue experimenting with various
36 arrangements subject to market conditions and shareholder priorities.

37
38 **AMA POLICY**

39
40 The AMA supports preserving the value of the private practice of medicine and its benefit to
41 patients. AMA will:

- 42
43 a. Utilize its resources to protect and support the continued existence of solo and small group
44 medical practice and to protect and support the ability of these practices to provide quality
45 care. They will also advocate in Congress to ensure adequate payment for services
46 rendered by private practicing physicians.
47 b. Work through the appropriate channels to preserve choices and opportunities, including the
48 private practice of medicine, for new physicians whose choices and opportunities may be
49 limited due to their significant medical education debt. The organization will work through
50 the appropriate channels to ensure that medical students and residents during their training
51 are educated in all of medicine's career choices, including the private practice of medicine.

- 1 c. Create, maintain and make accessible to medical students, residents and fellows, and
2 physicians resources to enhance satisfaction and practice sustainability for physicians in
3 private practice.
- 4 d. Create and maintain a reference document establishing principles for entering into and
5 sustaining a private practice, and encourage medical schools and residency programs to
6 present physicians in training with information regarding private practice as a viable
7 option.
- 8 e. Issue a report in collaboration with the Private Practice Physicians Section at least every
9 two years communicating their efforts to support independent medical practices (Policy D-
10 405.988, “The Preservation of the Private Practice of Medicine”).
11

12 The AMA also supports the consideration of prospective payment elements in the development of
13 payment and delivery reform that are consistent with AMA principles, as well as the following
14 principles to support physicians who choose to participate in prospective payment models:

- 15 a. The AMA, state medical associations and national medical specialty societies should be
16 encouraged to continue to provide guidance and support infrastructure that allows
17 independent physicians to join with other physicians in clinically integrated networks,
18 independent of any hospital system.
- 19 b. Prospective payment model compensation should incentivize specialty and primary care
20 collegiality among independently practicing physicians.
- 21 c. Prospective payment models should take into consideration clinical data, where
22 appropriate, in addition to claims data.
- 23 d. Governance within the model must be physician-led and autonomous.
- 24 e. Physician practices should be encouraged to work with field advisors on patient
25 attributions and a balanced mix of payers.
- 26 f. Quality metrics used in the model should be clinically meaningful and developed with
27 physician input.
- 28 g. Administrative burdens, such as those related to prior authorization, should be reduced for
29 participating physicians (Policy H-385.904, “Prospective Payment Model Best Practices
30 for Independent Private Practice”).
31

32 The AMA will identify financially viable prospective payment models and develop educational
33 opportunities for physicians to learn and collaborate on best practices for such payment models for
34 physician practice, including but not limited to independent private practice (Policy H-385.904,
35 “Prospective Payment Model Best Practices for Independent Private Practice”).
36

37 Additionally, the AMA supports flexibility in the design and implementation of value-based
38 insurance design (VBID) programs, consistent with the following principles:

- 39 a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers
40 the clinical benefit of a given service or treatment when determining cost-sharing structures or
41 other benefit design elements.
- 42 b. Practicing physicians must be actively involved in the development of VBID programs. VBID
43 program design related to specific medical/surgical conditions must involve appropriate
44 specialists.
- 45 c. High-quality, evidence-based data must be used to support the development of any targeted
46 benefit design. Treatments or services for which there is insufficient or inconclusive evidence
47 about their clinical value should not be included in any targeted benefit design elements of a
48 health plan.
- 49 d. The methodology and criteria used to determine high- or low-value services or treatments must
50 be transparent and easily accessible to physicians and patients.

- 1 e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and
2 patients. Educational materials should be made available to help patients and physicians
3 understand the incentives and disincentives built into the plan design.
- 4 f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to
5 target specific services or treatments but should not otherwise limit patient care choices.
- 6 g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs
7 that include higher cost-sharing or other disincentives to obtaining services designated as low-
8 value must include an appeals process to enable patients to secure care recommended by their
9 physicians, without incurring cost-sharing penalties.
- 10 h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation
11 and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure
12 VBID coverage rules are updated in accordance with evolving evidence.
- 13 i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines
14 (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or
15 restricted networks (Policies H-450.941 and D-285.972) (Policy H-185.939, “Value-Based
16 Insurance Design”).

17
18 The AMA will also study and clarify the ethical challenges and considerations regarding physician
19 professionalism raised by the advent and expansion of private equity ownership or management of
20 physician practices and report back on the status of any ethical dimensions inherent in these
21 arrangements, including consideration of the need for ethical guidelines as appropriate. Such a
22 study should evaluate the impact of private equity ownership, including but not limited to the effect
23 on the professional responsibilities and ethical priorities for physician practices (Policy D-140.951,
24 “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices”).

25
26 Moreover, the AMA encourages physicians who are contemplating corporate investor partnerships
27 to consider the following guidelines:

- 28 a. Physicians should consider how the practice’s current mission, vision and long-term goals
29 align with those of the corporate investor.
- 30 b. Due diligence should be conducted that includes, at minimum, review of the corporate
31 investor’s business model, strategic plan, leadership and governance and culture.
- 32 c. External legal, accounting and/or business counsels should be obtained to advise during the
33 exploration and negotiation of corporate investor transactions.
- 34 d. Retaining negotiators to advocate for best interests of the practice and its employees should
35 be considered.
- 36 e. Physicians should consider whether and how corporate investor partnerships may require
37 physicians to cede varying degrees of control over practice decision-making and day-to-
38 day management.
- 39 f. Physicians should consider the potential impact of corporate investor partnerships on
40 physician and practice employee satisfaction and future physician recruitment.
- 41 g. Physicians should have a clear understanding of compensation agreements, mechanisms
42 for conflict resolution, processes for exiting corporate investor partnerships, and
43 application of restrictive covenants.
- 44 h. Physicians should consider corporate investor processes for medical staff representation on
45 the board of directors and medical staff leadership selection.
- 46 i. Physicians should retain responsibility for clinical governance, patient welfare and
47 outcomes, physician clinical autonomy and physician due process under corporate investor
48 partnerships.
- 49 j. Each individual physician should have the ultimate decision for medical judgment in
50 patient care and medical care processes, including supervision of non-physician
51 practitioners.

- 1 k. Physicians should retain primary and final responsibility for structured medical education
2 inclusive of undergraduate medical education including the structure of the program,
3 program curriculum, selection of faculty and trainees, as well as education and disciplinary
4 issues related to these programs (Policy H-160.891, “Corporate Investors”).
5

6 Further, the AMA supports improved transparency regarding corporate investment in physician
7 practices and subsequent changes in health care prices, encourages national medical specialty
8 societies to research and develop tools and resources on the impact of corporate investor
9 partnerships on patients and the physicians in practicing in that specialty and supports
10 consideration of options for gathering information on the impact of private equity and corporate
11 investors on the practice of medicine (Policy H-160.891, “Corporate Investors”).
12

13 Additionally, AMA policy states that any individual, company, or other entity that establishes
14 and/or operates worksite health clinics should adhere to the following principles:

- 15 a. Worksite health clinics must have a well-defined scope of clinical services, consistent with
16 state scope of practice laws.
- 17 b. Worksite health clinics must establish a referral system with physician practices or other
18 facilities for appropriate treatment if the patient's conditions or symptoms are beyond the
19 scope of services provided by the clinic.
- 20 c. Worksite health clinics that use nurse practitioners and other health professionals to deliver
21 care must establish arrangements by which their health care practitioners have direct access
22 to MD/DOs, as consistent with state laws.
- 23 d. Worksite health clinics must clearly inform patients in advance of the qualifications of the
24 health care practitioners who are providing care, as well as the limitation in the types of
25 illnesses that can be diagnosed and treated.
- 26 e. Worksite health clinics should develop expertise in specific occupational hazards and
27 medical conditions that are likely to be more common in the particular industry where the
28 company offers products and services.
- 29 f. Worksite health clinics must use evidence-based practice guidelines to ensure patient
30 safety and quality of care.
- 31 g. Worksite health clinics must measure clinical quality provided to patients and participate in
32 quality improvement efforts in order to demonstrate improvement in their system of care.
- 33 h. Worksite health clinics must adopt explicit and public policies to assure the security and
34 confidentiality of patients' medical information. Such policies must bar employers from
35 unconsented access to identifiable medical information so that knowledge of sensitive facts
36 cannot be used against individuals.
- 37 i. Worksite health clinics must establish protocols for ensuring continuity of care with
38 practicing physicians within the local community. Such protocols must ensure after-hours
39 access of employees and eligible family members, as well as the transmission of reports of
40 all worksite clinic visits and treatments to the physicians of patients with an identified
41 community physician.
- 42 j. Worksite health clinics administering immunizations must establish processes to ensure
43 communication to the patient's medical home and the state immunization registry
44 documenting what immunizations have been given.
- 45 k. Patient cost-sharing for treatment received outside of the clinic must be affordable and not
46 prohibit necessary access to care.
- 47 l. Worksite health clinics should allow the involvement of community physicians in clinic
48 operations.
- 49 m. Employers implementing worksite health clinics should communicate the eligibility for
50 services of employees' family members.

- 1 n. Worksite health clinics should be encouraged to use interoperable electronic health records
2 as a means of communicating patient information to and facilitating continuity of care with
3 community physicians, hospitals and other health care facilities (Policy H-160.910,
4 “Worksite Health Clinics”).
5

6 The AMA also acknowledges that the corporate practice of medicine: (1) has the potential to erode
7 the patient-physician relationship; and (2) may create a conflict of interest between profit and best
8 practices in residency and fellowship training (Policy H-160.887, “Corporate Practice of
9 Medicine”).
10

11 Furthermore, (1) the AMA vigorously opposes any effort to pass federal legislation preempting
12 state laws prohibiting the corporate practice of medicine; (2) At the request of state medical
13 associations, the AMA will provide guidance, consultation, and model legislation regarding the
14 corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed
15 physicians in non-hospital settings and physicians contracting with corporately-owned management
16 service organizations; and (3) the AMA will continue to monitor the evolving corporate practice of
17 medicine with respect to its effect on the patient-physician relationship, financial conflicts of
18 interest, patient-centered care and other relevant issues (Policy H-215.981, “Corporate Practice of
19 Medicine”).
20

21 DISCUSSION

22 *Opportunities for Corporation-Provided Health Care*

23 Large corporations, equipped with large amounts of capital, massive active user bases, and data and
24 technology capabilities, have the potential to offer greater options for how patients receive care and
25 streamline and automate processes to potentially alleviate high costs, burnout and inefficiencies.
26
27

28 Additionally, large corporations, which collect and maintain significant amounts of customer data,
29 claim to utilize this data to address social determinants of health. For example, Dollar General and
30 Walmart plan to expand access to care in rural communities, and Walmart is prioritizing diversity
31 in clinical trials, as 20 percent of drugs reportedly respond differently across ethnic groups.^{5,18}
32
33

34 Further, new venture capital-backed companies, of which many are physician-led, are specifically
35 designed to provide opportunities to improve the care delivery and financial sustainability of
36 underinvested-in small to medium-independent physician practices.
37

38 *Challenges for Corporation-Provided Health Care*

39 Trust and a lack of health care background remain significant barriers to success for large
40 corporations, particularly Big Tech companies such as Apple, Google, Microsoft and Amazon. For
41 example, consumers, regulators and privacy advocates have all raised concerns about the
42 implications of Big Tech having access to patient’s health records, as well as a potential
43 cybersecurity crisis.^{5,12} This concern has only further intensified following the overturning of *Roe*
44 *v. Wade*, which sparked questions about the use of personal data to surveil people seeking
45 reproductive health services.¹²
46
47

48 Others have pointed to the underperformance of large corporations’ investments in health care. For
49 instance, Haven, an effort by Amazon, JPMorgan Chase and Berkshire Hathaway that sought to
50 reduce health care costs and improve patient outcomes, failed after just two years. Additionally,
51 margins in health care are small. As large corporations are used to high margins and rapidly scaled

1 businesses, some experts question their preparedness for the health care industry where profit
2 margins are typically small.²⁸

3
4 Further, common adverse effects of mergers and acquisitions on physicians include workflow
5 disruptions, organizational changes that may increase workloads and staff burden, technological
6 transitions such as shifts in EHR implementation and even lower wages. Athenahealth’s 2021
7 Physician Sentiment Index report demonstrated that physicians undergoing a merger or acquisition
8 expressed less willingness to remain at their organization and were more likely to experience
9 burnout. While 68 percent of physician respondents undergoing a merger or acquisition reported
10 that they would recommend their health care organization to friends or family, 85 percent of
11 physicians not undergoing a merger or acquisition reported that they would recommend their
12 organization to loved ones. The National Institute for Health Care (NIHCM) Foundation found that
13 after a hospital merger, skilled workers experienced a four percent decrease in wages, and nurses
14 and pharmacy workers saw a 6.8 percent decrease.²⁹

15
16 Finally, value-based payment models have persistent and ongoing methodologic and
17 implementation challenges for payers, large integrated health care systems and independent private
18 practices alike, including designing adequate risk models, measuring quality, providing access to
19 timely and actionable data, and imposing significant administrative burdens. These fundamental
20 design and implementation challenges must be addressed to ensure sustainable success for any of
21 these investments.^{30,31}

22 23 CONCLUSION

24
25 With the continued growth of corporate entrants in care delivery pursuing new practice ownership
26 strategies and delivery models, particularly among small-to-medium-sized physician practices, this
27 report highlights opportunities for the AMA to work directly with corporate entities to advocate for
28 and support independent physician practices in communities. Health care costs continue to
29 increase, and the quality of and access to care continues to erode in many local communities. Thus,
30 we support corporate entities to work with and assist independent physician practices with the
31 capabilities to deliver highly coordinated care that is critical to improving patient outcomes and
32 competition in many markets.

33 34 RECOMMENDATIONS

35
36 The Board of Trustees recommends that the following be adopted and the remainder of the report
37 be filed:

- 38
39 1. That our American Medical Association (AMA) reaffirm the following policies:
40 a. D-405.988, “The Preservation of the Private Practice of Medicine”
41 b. H-385.904, “Prospective Payment Model Best Practices for Independent Private
42 Practice”
43 c. H-185.939, “Value-Based Insurance Design”
44 d. D-140.951, “Establishing Ethical Principles for Physicians Involved in Private
45 Equity Owned Practices”
46 e. H-160.891, “Corporate Investors”; (Reaffirm HOD Policy) and
47
48 2. That our AMA will: (1) inform corporate efforts about the value of private practices to
49 successfully participate in new “value-based” models; (2) identify and work with a
50 corporate entity that is advancing these models to explore a two year pilot among
51 independent private practices in which the AMA will: (a) convene physician practices in a

- 1 community; (b) provide educational resources and technical assistance to practices to
2 support their participation with the corporate entity and (c) formally evaluate the pilot for
3 outcomes; and (3) advocate with commercial payers and health plans and federal and state
4 payers and policymakers to support private practice through policies and models that
5 provide adequate payment, infrastructure and data to succeed in “value-based” models.
6 (Directive to Take Action)
- 7 3. That Policy D-160.912 be rescinded as having been accomplished by this report. (Rescind
8 HOD Policy)

Fiscal Note: \$274,962

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-A-23

Subject: Council on Medical Service Sunset Review of 2013 House Policies

Presented by: Lynn Jeffers, MD, Chair

Referred to: Reference Committee G

1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.110 reads as follows:
4

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

1 RECOMMENDATION

2

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

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-130.965	On-Call Coverage Models	Our AMA will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands and educate AMA physician members regarding these options.	Retain. Still relevant.
D-160.934	Physician Participation in Multiple Medicare Accountable Care Organizations	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to address accountable care organization (ACO) rules that preclude physician participation in multiple Medicare ACOs.	Retain. Still relevant.
D-165.939	Transitional Reinsurance Fees Under the Affordable Care Act	Our AMA will advocate that any proposed assessment on “issuers of insurance” (scheduled to commence in 2014 for a 3-year period), intended to fund a “risk adjustment program” to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, be taken from administrative and medical management costs.	Retain-in-part. All is still relevant other than “(scheduled to commence in 2014 for a 3-year period),” which should be removed.
D-165.955	Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured	<p>1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.</p> <p>2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if</p>	<p>Rescind. Superseded by Policies H-165.920, H-165.865, D-290.979, H-165.823, and H-165.904.</p> <p>Individual Health Insurance H-165.920 Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary</p>

POLICY #	Title	Text	Recommendation
		<p>they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.</p>	<p>interim step toward universal access;</p> <p>(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:</p> <p>(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;</p> <p>(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;</p> <p>(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and</p> <p>(d) Work toward establishment of safeguards, such as a health</p>

POLICY #	Title	Text	Recommendation
			<p>care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;</p> <p>(4) will identify any further means through which universal coverage and access can be achieved;</p> <p>(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;</p> <p>(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;</p> <p>(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;</p> <p>(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health</p>

POLICY #	Title	Text	Recommendation
			<p>insurance premium expenditures;</p> <p>(9) supports legislation requiring a “maintenance of effort” period, such as one or two years, during which employers would be required to add to the employee’s salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;</p> <p>(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;</p> <p>(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;</p> <p>(12) supports a replacement of the present federal income tax exclusion from employees’ taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;</p>

POLICY #	Title	Text	Recommendation
			<p>(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and</p> <p>(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.</p> <p>(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.</p> <p>Medicaid Expansion D-290.979</p> <p>Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.</p> <p>2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and</p>

POLICY #	Title	Text	Recommendation
			<p>H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.</p> <p>Principles for Structuring a Health Insurance Tax Credit H-165.865</p> <p>(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-</p>

POLICY #	Title	Text	Recommendation
			<p>income persons who could not afford the monthly out-of-pocket premium costs.</p> <p>(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.</p> <p>(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.</p> <p>Options to Maximize Coverage under the AMA Proposal for Reform H-165.823</p> <p>That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.</p> <p>2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:</p> <ul style="list-style-type: none"> a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored

POLICY #	Title	Text	Recommendation
			<p>coverage that meets standards for minimum value of benefits.</p> <p>c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.</p> <p>d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.</p> <p>e. The public option is financially self-sustaining and has uniform solvency requirements.</p> <p>f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.</p> <p>g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.</p> <p>3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:</p> <p>a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.</p>

POLICY #	Title	Text	Recommendation
			<p>b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.</p> <p>c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.</p> <p>d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.</p> <p>e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.</p> <p>f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.</p> <p>g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.</p> <p>h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a</p>

POLICY #	Title	Text	Recommendation
			<p>special enrollment period.</p> <p>4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.</p> <p>Universal Health Coverage H-165.904</p> <p>Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide</p>

POLICY #	Title	Text	Recommendation
			financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans.
D-185.983	Diabetic Documentation Requirements	<p>1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies.</p> <p>2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.</p>	Rescind. Directive accomplished. Research by the AMA Office of General Counsel indicated a reasonable basis did not exist for bringing a lawsuit against CMS related to diabetic documentation requirements.
D-225.986	Blue Cross of California Quality of Care Allegations	Our AMA will reiterate its position stating that medical staffs shall not be impugned and quality of care issues not be imposed between insurance plans and hospitals as a means of addressing economic or contractual issues.	Retain. Still relevant.
D-225.988	Elimination of 48-Hour Signature Rule for Verbal Orders	Our AMA will, through the Organized Medical Staff Section, encourage hospital medical staffs to include policies, which consider	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws.	
D-235.986	Random Drug Screening	Our AMA will develop model medical staff bylaws addressing random drug testing of medical staffs.	Rescind. Directive accomplished. The AMA Physician's Guide to Medical Staff Organization Bylaws includes sample bylaws that address drug screening for medical staff (see Section 5.7, "Drug Testing," pages 90-94).
D-285.998	Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans	Our AMA will continue to work with America's Health Insurance Plans and other appropriate organizations on issues of mutual interest.	Retain. Still relevant.
D-330.941	Medicare Outpatient Therapy Caps	Our AMA will not support Medicare outpatient rehabilitation therapy caps.	Retain. Still relevant.
D-330.958	Social Security Disability Medical Benefits	Our AMA will take an active role in supporting reduction of the waiting period to receive Social Security Disability medical benefits.	Retain. Still relevant.
D-330.961	Social Security Disability Medical Benefits	Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients and will report and recommend further action to the House of Delegates as appropriate.	Retain. Still relevant.
D-335.983	Review of Self-Administered Drug List Alterations Under Medicare Part B	Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.	Retain. Still relevant. SAD List approval does not yet involve Carrier Advisory Committee review and advisement.
D-390.975	Payment for Facilities Expenses in Physicians' Offices	Our AMA will (1) advocate that CMS increase allowed expenditures subject to the SGR target whenever CMS assigns new office expenses to codes that historically have only been performed in the hospital; and (2) incorporate this	Rescind. MACRA repealed the SGR.

POLICY #	Title	Text	Recommendation
		recommended administrative change into the other SGR system changes our AMA has advocated, such as removing drug spending from the SGR system and recognizing new coverage decisions.	
D-390.983	CMS Pharmaceutical Reimbursement Method	Our AMA will work to exclude pharmaceutical costs from the Sustainable Growth Rate formula.	Rescind. MACRA repealed the SGR.
D-400.985	Geographic Practice Cost Index	Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPICs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.	Retain-in-part: (4) (1) & (3) Accomplished; (2) Addressed by CMS . Suggest revising policy title to “MEI GPCI Impacts on the Physician Payment Schedule.”
D-440.937	Vaccines for Children Program and the New CPT Codes for Immunization Administration	Our AMA will work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
D-450.960	Improve the HCAHPS Rating System	Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.	Rescind. The directive was accomplished by correspondence sent to CMS .
D-450.963	Align the Recognition Periods for the Bridges to Excellence and the National Committee on Quality Assurance Recognition Programs	Our AMA will request the Bridges to Excellence program to align its validation periods for its recognition programs with the validation periods of the National Committee on Quality Assurance recognition programs.	Rescind. Directive accomplished. A letter was sent to the Executive Director of the Health Care Incentives Improvement Institute requesting that the Bridges to Excellence program align its validation periods with those of the NCQA.
D-510.999	Veterans Health Administration Health Care System	Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient’s health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA’s payment for prescriptions written by physicians who have no formal affiliation with the VHA.	<p>Retain-in-part. The following subsections are superseded by Policy H-510.983:</p> <p>(1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and</p> <p>Expansion of U.S. Veterans Health Care Choices H-510.983</p> <p>1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.</p>

POLICY #	Title	Text	Recommendation
			<p>2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.</p> <p>3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.</p> <p>4. Our AMA will support consolidation of all the VA community care programs.</p> <p>5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.</p> <p>6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.</p> <p>7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.</p> <p>8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.</p> <p>9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.</p>

POLICY #	Title	Text	Recommendation
			10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
H-120.978	Principles of Drug Utilization Review	<p>Our AMA adopts the following Principles of Drug Utilization Review.</p> <p>Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy.</p> <p>Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.</p> <p>Principle 2: Criteria and standards for DUR must be clinically relevant.</p> <p>Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.</p> <p>Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>through an open professional consensus process.</p> <p>Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.</p> <p>Principle 4: Interventions must focus on improving therapeutic outcomes.</p> <p>Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or</p>	

POLICY #	Title	Text	Recommendation
		<p>obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.</p> <p>Principle 5: Confidentiality of the relationship between patients and practitioners must be protected.</p> <p>Characteristic: The DUR program must assure the security of its database.</p> <p>Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.</p> <p>Principle 7: The DUR program operations must be structured to achieve the principles of DUR.</p> <p>Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.</p>	
H-120.981	Drug Utilization Review	<p>(1) Our AMA supports DUR programs provided: (a) primary emphasis is placed on high quality patient care through improved prescribing by physicians, dispensing by pharmacists, and medication compliance by patients; (b) physicians are actively involved in the development, implementation, and maintenance of the DUR programs; (c) criteria and</p>	<p>Rescind. Superseded by Policy H-120.978.</p> <p>Principles of Drug Utilization Review H-120.978 Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a</p>

POLICY #	Title	Text	Recommendation
		<p>standards for prescribing are developed by physician organizations and they are based on the peer-reviewed medical literature and the experiences of physicians with expertise in drug therapy; (d) focused professional education is emphasized as the primary intervention strategy to improve physician prescribing, pharmacist dispensing, and patient compliance practices; and (e) the confidentiality relationship between physicians and their patients is maintained.</p> <p>(2) Our AMA supports interacting with appropriate pharmacy organizations to develop guidelines for prospective (point-of-sale) DUR that will decrease the incidence of adverse events from drug therapy.</p> <p>(3) Our AMA recognizes the right of government and private third party payers to include in DUR programs a component that addresses fraud and abuse, but reaffirms the right of physicians, who are so accused, to due process.</p> <p>(4) Our AMA opposes DUR programs of government or private third party payers that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients.</p>	<p>desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.</p> <p>Principle 2: Criteria and standards for DUR must be clinically relevant.</p> <p>Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.</p> <p>Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed</p>

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			<p>and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.</p> <p>Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.</p> <p>Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database.</p> <p>Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.</p> <p>Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR</p>

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			<p>programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.</p>
H-130.955	Patient Responsibility of On-Call Physicians	<p>The AMA urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department.</p>	Retain. Still relevant.
H-160.910	Worksite Health Clinics	<p>It AMA policy that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles:</p> <p>a) Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws.</p> <p>b) Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.</p> <p>c) Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>consistent with state laws.</p> <p>d) Worksite health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.</p> <p>e) Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services.</p> <p>f) Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care.</p> <p>g) Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care.</p> <p>h) Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals.</p> <p>i) Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians</p>	

POLICY #	Title	Text	Recommendation
		<p>of patients with an identified community physician.</p> <p>j) Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given.</p> <p>k) Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care.</p> <p>l) Worksite health clinics should allow the involvement of community physicians in clinic operations.</p> <p>m) Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members.</p> <p>n) Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.</p>	
H-160.911	Value of Group Medical Appointments	Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.	Retain. Still relevant.
H-160.952	Access to Specialty Care	The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-	Rescind. Accomplished through CMMI TCPI .

POLICY #	Title	Text	Recommendation
		<p>referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.</p>	
H-160.988	Health Care Coalitions	<p>The AMA (1) supports health care coalitions that include strong physician participation so that primary emphasis is given to the quality, availability and access to medical care; and (2) encourages physicians in the clinical practice of medicine to take an active role in the development and activities of health care coalitions in their respective areas.</p>	Retain. Still relevant.
H-165.830	Health Insurance Cancellations	<p>Our AMA supports urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer ‘meaningful coverage’ as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.</p>	Retain. Still relevant for grandfathered plans.
H-185.961	Health Plan Coverage of Prescription Drugs	<p>It is the policy of our AMA that third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage</p>	<p>Amend Policy H-110.990 to include specification of medical exception process.</p> <p>Cost Sharing Arrangements for Prescription Drugs H-110.990</p>

POLICY #	Title	Text	Recommendation
		<p>under a medical exceptions process.</p>	<p>Our AMA:</p> <ol style="list-style-type: none"> 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and 4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information. <u>5. payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.</u>

POLICY #	Title	Text	Recommendation
H-185.962	Payment for Advanced Technologies	Our AMA vigorously opposes actions by medical insurers to deny payment for services simply on the basis of the size of medical equipment.	Retain. Still relevant.
H-185.967	Coverage of Children's Deformities, Disfigurement and Congenital Defects	<p>1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed.</p> <p>2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-185.981	Third Party Responsibility for Payment	<p>Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.</p>	<p>Rescind. ACA established EHBs and HHS Administrative Simplification Eligibility and Benefits Transaction covers inquiries and responses about a patient’s eligibility for insurance benefits.</p>
H-185.983	Patient's Out-of-Pocket Contributions to Private Health Insurance	<p>(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to</p>	<p>Retain. Still relevant. Suggest revising every iteration of “copayments” to “copayments and coinsurance.”</p>

POLICY #	Title	Text	Recommendation
		<p>the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.</p>	
H-190.956	Errors in Electronic Claims	<p>Our AMA will publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims, and advocates that at the time of claim confirmation or no later than two business days after receiving an electronic claim, a third-party payer should provide the physician with an exception report notifying the physician of all information that is missing from the claim, any errors in the claim, any attachment that is missing or in error, and any other circumstances which preclude the claim from being a clean claim.</p>	Retain. Still relevant.
H-190.983	Submission of Electronic Claims Through Electronic Data Interchange	<p>The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine; (2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide electronic reconciliation prior to physicians being required to transmit electronic claims; (3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill</p>	<p>Rescind. Superseded by Policy H-190.978.</p> <p>Promoting Electronic Data Interchange H-190.978 Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's</p>

POLICY #	Title	Text	Recommendation
		<p>electronically; and (4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.</p>	<p>Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for “clean” paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange</p>

POLICY #	Title	Text	Recommendation
			<p>(EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and. (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.</p>
H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	<p>(1) Health Insurance</p> <p>A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.</p> <p>(2) Disability Coverage</p> <p>a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>accordingly. The policy selected should contain a reasonable definition of “sickness” or “disability,” an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;</p> <p>b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;</p> <p>c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.</p>	
H-190.991	Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims	<p>1. It is the policy of our AMA (A) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (B) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis.</p> <p>2. Our AMA will: (A) work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review,</p>	<p>Rescind. Superseded by Policy H-190.981.</p> <p>Required Timely Reimbursements by all Health Insurers H-190.981 Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for “clean” claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.</p>

POLICY #	Title	Text	Recommendation
		<p>prior to payment; and (B) work with payers to establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims.</p> <p>3. If efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA will seek legislation that would accomplish this.</p>	

<p>H-190.992</p>	<p>Electronic Claims Submission</p>	<p>It is the policy of the AMA to: (1) support, assist and encourage the use of electronic data interchange (EDI) and electronic media claims (EMC) by physicians; (2) support and continue its involvement in the development of uniform EMC format and technical requirements; (3) continue to support the elimination of the Medicare 14-day payment delay regulation following Medicare carrier receipt of a claim; and (4) oppose the establishment, at this time, of any time tables or plans for mandatory EMC or EDI use by physicians.</p>	<p>Rescind. Superseded by Policy H-190.978.</p> <p>Promoting Electronic Data Interchange H-190.978</p> <p>Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for “clean” paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and</p>
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POLICY #	Title	Text	Recommendation
			<p>NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to</p>

POLICY #	Title	Text	Recommendation
			improve the efficiency of electronic claims approval.
H-220.931	Evidence-Based Value of Joint Commission Standards and Measures	Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.	Retain. Still relevant.
H-220.991	AMA Policy on Hospital Accreditation	The AMA (1) believes that the objective of hospital accreditation should be primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; (2) opposes accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and (3) recognizes that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures or form of organization used to provide patient care.	Retain. Still relevant.
H-225.958	Insurance Plan Inquiries Regarding Quality of Care and Peer Review Issues	Our AMA insists that all insurance plan inquiries regarding quality of care and peer review issues be evaluated through objective due process and peer review; and supports a position stating that all future peer review and quality of care issues between insurance companies and medical staffs be brought to an objective	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		and neutral peer review body.	
H-225.962	Medical Staff Membership Category for Physicians Providing Telemedicine	The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.	Retain. Still relevant.
H-225.968	Standard Admitting Orders	It is the policy of the AMA that any standard admitting orders are the responsibility of and should be developed and approved by the medical staff.	Retain. Still relevant.
H-225.970	Full Participation for All Members of Hospital Medical Staff	The AMA opposes efforts by hospital administrations or governing boards to abrogate the voting rights of the physicians who serve on the medical executive committee. The AMA will communicate to its members its strong concern about hospital administrations' or governing boards' efforts to limit the participation of any physician who serves on the medical executive committee in the self-governing medical staff.	Retain. Still relevant. Will be discussed by OMSS Policy Committee.

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H-225.985	Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract	The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.	Retain. Still relevant.
H-225.996	Computer-Based Hospital and Order System	The AMA supports the concept of early involvement and participation by the hospital medical staff in decisions as to installation of a hospital information system and in the development of policies governing the use of such a system in the institution.	Retain. Still relevant.
H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	1. Our AMA adopted as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the	Retain. Still relevant.

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		<p>requirements of the medical staff bylaws.</p> <p>2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.</p> <p>3. Our AMA encourages medical staffs and their advisors to consult the AMA Physician's Guide to Medical Staff Organization Bylaws and the AMA Conflict of Interest Guidelines for Organized Medical Staffs when developing policies for the disclosure of medical staff leaders' personal or financial affiliations or relationships and the management of resulting conflicts of interest.</p>	
H-235.962	Medical Staff-Hospital Compacts	<p>1. Given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, our AMA recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the AMA encourages organized medical staffs and hospital governing bodies to:</p> <p>A. Clearly define within the medical staff bylaws the</p>	Retain. Still relevant.

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		<p>obligations of each party; B. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and C. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. 2. Our AMA will publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify as needed the Physician's Guide to Medical Staff Organization Bylaws.</p>	
H-235.964	Preservation of Medical Staff Self-Governance	Our AMA strongly supports any hospital medical staff whose rights of self-governance are being threatened by the hospital administration or the governing body.	Retain. Still relevant.
H-235.972	Proxy Voting at Medical Staff Meetings	It is the policy of the AMA that proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws.	Retain. Still relevant.
H-280.948	Long-Term Care Residents With Criminal Backgrounds	1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while	Retain. Still relevant.

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		<p>ensuring the safety of all residents of the facilities.</p> <p>2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.</p> <p>3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.</p> <p>4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.</p>	
H-285.928	Health Plan and Fiscal Intermediary Insolvency Protection Measures	<p>(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal</p>	Retain. Still relevant.

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		<p>intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice associations, and groups that assume financial risk unrelated to direct provision of patient care.</p>	
H-285.929	Patient Notification of Physician Contract Termination	<p>Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician’s contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies.</p>	<p>Rescind. Superseded by Policy H-225.950.</p> <p>AMA Principles for Physician Employment H-225.950</p> <p>1. Addressing Conflicts of Interest</p> <p>a) A physician’s paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.</p> <p>b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these</p>

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			<p>interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.</p> <p>c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.</p> <p>d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.</p> <p>(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and</p> <p>(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.</p> <p>e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the</p>

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			<p>practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.</p> <p>2. Advocacy for Patients and the Profession</p> <p>a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.</p> <p>b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.</p> <p>3. Contracting</p> <p>a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.</p> <p>b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.</p>

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			<p>c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.</p> <p>d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations,</p>

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			<p>or other proceedings against the physician.</p> <p>(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.</p> <p>(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.</p> <p>(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a</p>

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			<p>specified area upon termination of employment.</p> <p>(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.</p> <p>4. Hospital Medical Staff Relations</p> <p>a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.</p> <p>b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.</p> <p>c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.</p> <p>d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.</p>

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			<p>5. Peer Review and Performance Evaluations</p> <p>a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.</p> <p>b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.</p> <p>c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.</p> <p>d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.</p> <p>e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed</p>

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			<p>physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.</p> <p>(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:</p> <ul style="list-style-type: none"> i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned

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			<p>upon termination of the agreement.</p> <p>6. Payment Agreements</p> <p>a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.</p> <p>b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.</p>
H-285.931	The Critical Role of Physicians in Health Plans and Integrated Delivery Systems	<p>Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS):</p> <p>(1) Practicing physicians participating in a health plan/IDS must:</p> <p>(a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing</p>	Retain. Still relevant.

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		<p>body or management;</p> <p>(b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;</p> <p>(c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine;</p> <p>(d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and</p> <p>(e) have access to a due process system.</p> <p>(2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.</p> <p>(3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.</p> <p>(4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.</p> <p>(5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians</p>	

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		<p>serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.</p> <p>(6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.</p> <p>(7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.</p> <p>(8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.</p> <p>(9) Physician representatives/leaders must communicate key policies</p>	

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		<p>and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.</p> <p>(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice.</p> <p>Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.</p>	
H-285.940	Denials of Payment for Necessary Services Because of Lack of Authorization	<p>1. Our AMA seeks the elimination of clauses in managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner.</p> <p>2. Our AMA supports a requirement that payers provide a retro-authorization process, with reasonable timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization.</p>	<p>Rescind. Superseded by Policy H-320.939.</p> <p>Prior Authorization and Utilization Management Reform H-320.939</p> <p>1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.</p> <p>2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same</p>

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			<p>medical specialty/subspecialty as the prescribing/ordering physician.</p> <p>3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.</p> <p>4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.</p>
H-315.973	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	<p>1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:</p> <p>a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.</p> <p>b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.</p> <p>c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.</p> <p>d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims,</p>	<p>Rescind. Superseded by Policy D-478.995.</p> <p>National Health Information Technology D-478.995</p> <p>1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.</p> <p>2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C)</p>

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		<p>eligibility) must be compensated by the entity requesting the data.</p> <p>e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.</p> <p>f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.</p> <p>g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.</p> <p>h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.</p> <p>2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:</p> <p>a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.</p> <p>b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.</p> <p>c. Physician and patient</p>	<p>advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.</p> <p>3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.</p> <p>4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.</p>

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		<p>permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.</p> <p>d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.</p>	<p>5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.</p> <p>6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.</p> <p>7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.</p> <p>8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.</p> <p>9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.</p>
H-320.963	Disclosure of Medical Review Criteria and Eligibility Guidelines	The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens, frequency parameters, and computer edits to identify claims for medical review.	<p>Rescind. Superseded by Policies H-320.948 and H-340.898.</p> <p>Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948</p> <p>It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient</p>

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			<p>who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.</p> <p>Medicare Review Activities H-340.898</p> <p>Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input on the Medicare Integrity Program; (2) continues to oppose any type of “bounty” system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies; (3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing any Medicare review contractor’s activities and the need to emphasize physician education and clinical improvements; (4) urges CMS to delete all “incentives” or other “award fees” for any Medicare review contractor; and (5) urges CMS to clarify that in any Statement of Work or contract with a Medicare review contractor that: (a) extrapolation should not occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of Inspector General should not occur unless a hospital does not respond to intervention or</p>

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			when significant evidence of fraud exists.
H-330.886	Strengthening Medicare Through Competitive Bidding	<p>1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:</p> <ul style="list-style-type: none"> a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries. b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks. c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses. d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region. e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area. f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums. g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans. <p>2. Our AMA supports using a competitive bidding</p>	Retain. Still relevant.

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		process to determine federal payments to Medicare Advantage plans.	
H-330.902	Subsidizing Prescription Drugs for Elderly Patients	Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing.	Retain. Policy remains relevant through implementation of the IRA.
H-330.952	Medicare Carrier Advisory Committee	The AMA will advocate to all relevant parties (e.g., CMS and Medicare carriers) that the role of the state medical associations and state specialty societies in representing the interests and views of physicians in their respective states should not in any way be diminished by the operations of the Medicare Carrier Advisory Committee.	Retain. Still relevant.
H-330.958	Regionalization of Medicare Carriers	The AMA will continue to: (1) encourage state medical associations and national medical specialty societies to participate proactively in the Medicare Carrier "Notice and Comment" program with their respective carriers; and (2) monitor the impact of present and future Medicare carrier regionalization on the consistency of carrier interpretations and efficiency of operations.	Retain. Still relevant.
H-335.978	Medicare Fair Hearing	The AMA urges CMS to encourage Medicare carriers to utilize as Hearing Officers licensed physicians of the same specialty and in the same geographical area as that of the physician who requests the Fair Hearing and to make known to the requesting physician, prior to the Fair Hearing, the educational and medical credentials of the Hearing Officer.	Retain. Still relevant.
H-340.907	Notification When Physician Specific Information is Exchanged	The AMA will petition CMS to require notification of a physician under focused review that his or her name is being exchanged between any carrier and the QIOs and	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		to identify the reason for this exchange of information.	
H-365.997	Corporation or Employer-Sponsored Examinations	The AMA encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to his or her personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist him or her in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.	Retain. Still relevant.
H-373.999	Patient Advocacy/Protection Activities	The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms.	Retain. Still relevant.
H-375.977	Peer Review - Caused Litigation	The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-375.978	Medical Peer Review Outside Hospital Settings	The AMA requests state medical associations to study the need for, and if appropriate, to pursue the enactment of, legislation designed to protect the records of peer review activities in ambulatory health care facilities against discoverability in judicial or administrative proceedings.	Rescind. Accomplished.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	<p>1. Our AMA adopts as policy the following definitions:</p> <p>(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);</p> <p>(b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and</p> <p>(c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.</p> <p>2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-385.962	Physician Bargaining	<p>The AMA acknowledges that some state medical associations are in favor of a budgeting process that incorporates the ability for physician groups to bargain collectively on state-level budgets and will continue to support such state medical associations in their negotiations and development of budgeting process.</p>	<p>Rescind. Superseded by Policies H-165.888 and H-155.960.</p> <p>Evaluating Health System Reform Proposals H-165.888</p> <p>1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:</p> <p>A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.</p> <p>B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.</p> <p>C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.</p> <p>D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and</p>

POLICY #	Title	Text	Recommendation
			<p>procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.</p> <p>E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.</p> <p>F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.</p> <p>G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.</p> <p>H. True health reform is impossible without true tort reform.</p> <p>2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be</p>

POLICY #	Title	Text	Recommendation
			<p>specifically included in national health care reform legislation.</p> <p>3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.</p> <p>4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.</p> <p>Strategies to Address Rising Health Care Costs H-155.960</p> <p>Our AMA:</p> <p>(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;</p> <p>(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote “value-based decision-making” at all levels;</p> <p>(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and</p>

POLICY #	Title	Text	Recommendation
			<p>medical education and training;</p> <p>(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;</p> <p>(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;</p> <p>(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;</p> <p>(7) encourages third-party payers to use targeted benefit design, whereby patient cost-</p>

POLICY #	Title	Text	Recommendation
			<p>sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.</p> <p>(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.</p>
H-385.963	Physician Review of Accounts Sent for Collection	<p>(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-390.884	Medicare Policy Change	<p>Primary Care Consultation Policy: The AMA opposes Medicare’s policy regarding denial of payment for consultation provided by primary care physicians for patients who are being cleared for surgery, as this policy is contrary to the best interests of Medicare patients and the fundamental goals of RBRVS, and will take any measures possible to have this policy changed.</p>	<p>Rescind. Superseded by Policy D-70.953.</p> <p>Medicare’s Proposal to Eliminate Payments for Consultation Service Codes D-70.953</p> <p>Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services’ (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.</p>

POLICY #	Title	Text	Recommendation
H-390.891	Hospital Services Provided Within Three Days of Hospital Admission	The AMA will resist strongly efforts to incorporate payment for Medicare Part B physician services into hospital payments.	<p>Rescind. Superseded by Policy H-280.947.</p> <p>Three Day Stay Rule H-280.947</p> <ol style="list-style-type: none"> 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.
H-390.962	Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986	(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is \$500 or	<p>Rescind. Superseded by Policy H-335.992.</p> <p>Modifying the Medicare Unnecessary Services Program H-335.992</p> <p>(1) The AMA continues to support the repeal of the “medically unnecessary” provisions of Section 9332(c) of OBRA 1986. (2) Until such time as repeal is achieved, the AMA urges CMS to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person</p>

POLICY #	Title	Text	Recommendation
		<p>more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in schedules between participating and nonparticipating physicians</p>	<p>to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service.</p> <p>Additionally, Policy H-330.892 supports physician choice of Medicare participation.</p> <p>Medicare Participation Status H-330.982 It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status.</p>
H-390.992	Prospective Payment System and DRGs for Physicians	<p>The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.</p>	<p>Rescind. Superseded by Policy H-385.989.</p> <p>Payment for Physicians Services H-385.989 Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the</p>

POLICY #	Title	Text	Recommendation
			<p>right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.</p> <p>Additionally, Policy H-385.922 supports using the term “payment” instead of “reimbursement” as the term for compensating physicians.</p> <p>Payment Terminology H-385.922 It is AMA policy to change the terminology used in compensating physicians from “reimbursement” to “payment.”</p>
H-400.984	Geographic Practice Costs	1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic	Rescind. (1) Addressed by PPI ; (2) Addressed by CMS .

POLICY #	Title	Text	Recommendation
		<p>payment areas for use in the new Medicare physician payment system.</p> <p>2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices.</p>	
H-400.988	Medicare Reimbursement, Geographical Differences	<p>The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.</p>	<p>Rescind. Superseded by Policy H-155.957.</p> <p>Geographic Variation in Health Care Cost and Utilization H-155.957</p> <p>Our American Medical Association: (1) encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services; (2) encourages the development of interoperable national claims databases in order to facilitate research into health care utilization patterns across all segments of the health care delivery system; and (3) supports efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than solely on aggregated benchmarks.</p>

POLICY #	Title	Text	Recommendation
H-410.980	Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level	<p>Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..</p> <p>(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.</p> <p>(3) clinical practice guidelines that are selected for implementation at the local/state/regional level</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.</p> <p>(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.</p> <p>(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.</p> <p>(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.</p> <p>(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.</p> <p>(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate</p>	

POLICY #	Title	Text	Recommendation
		<p>documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.</p> <p>(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.</p> <p>(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.</p>	
H-415.999	Preferred Provider Organizations	<p>The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems.</p>	Retain. Still relevant.
H-440.840	Patient Access to Anti-Tuberculosis Medications	<p>Our AMA supports state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		this airborne infectious disease.	
H-465.982	Rural Health	The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.	Retain. Still relevant.
H-480.948	Medicare/Medicaid Coverage of Multi-Use Technology Platforms	AMA policy is that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.	<p>Rescind. Superseded by Policies H-480.943 and H-385.919.</p> <p>Integration of Mobile Health Applications and Devices into Practice H-480.943</p> <p>1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and</p>

POLICY #	Title	Text	Recommendation
			<p>interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.</p> <p>2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.</p> <p>3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.</p> <p>4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.</p>

POLICY #	Title	Text	Recommendation
			<p>5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.</p> <p>6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient’s understanding of such risks</p> <p>7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.</p> <p>8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.</p> <p>Payment for Electronic Communication H-385.919 Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.</p>
H-510.990	Health Care Policy for Veterans	Our AMA encourages the Department of Veterans Affairs to continue to	Rescind. Superseded by Policies H-510.983 and H-510.985 .

POLICY #	Title	Text	Recommendation
		<p>explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).</p>	<p>Expansion of US Veterans' Health Care Choices H-510.983</p> <ol style="list-style-type: none"> 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans. 2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission. 7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely

POLICY #	Title	Text	Recommendation
			<p>manner to ensure efficient care.</p> <p>9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.</p> <p>10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.</p> <p>Access to Health Care for Veterans H-510.985</p> <p>Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and</p>

POLICY #	Title	Text	Recommendation
			(6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
H-55.994	Coverage of Chemotherapy in Physicians' Offices	The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.	Retain. Still relevant.
H-55.995	Medicare Coverage of Outpatient Chemotherapy Drugs	Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings.	Retain. Still relevant.
H-70.980	Bundling CPT Codes	<ol style="list-style-type: none"> 1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of 	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>the existing codes and work with CMS to achieve a smooth transition for such codes.</p> <p>4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services.</p> <p>5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA.</p>	
H-75.988	Extension of Medicaid Coverage for Family Planning Services	The AMA supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women.	Retain. Still relevant.
H-90.971	Enhancing Accommodations for People with Disabilities	Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.	Retain. Still relevant.
H-90.986	SSI Benefits for Children with Disabilities	The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.	Retain. Still relevant.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 05-A-23

Subject: Prescription Drug Dispensing Policies
(Resolution 237-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

1 At the June 2022 Annual Meeting, the House of Delegates referred Resolution 237-A-22,
2 Prescription Drug Dispensing Policies, which was sponsored by the Ohio Delegation and asks that
3 the American Medical Association (AMA) work with pharmacy benefit managers (PBMs) to
4 eliminate any financial incentives that may exist for patients to receive a supply of medication that
5 is greater than the physician prescribed. Resolution 237-A-22 also asks that the AMA create model
6 state legislation to restrict dispensing a prescription drug in greater quantities than prescribed, and
7 support legislation that supports removing financial barriers that favor dispensing of quantities
8 greater than prescribed. This report provides background on the process of drug dispensing
9 quantities, reviews relevant AMA policy, and makes policy recommendations.

10
11 BACKGROUND

12
13 When physicians write prescriptions and provide them to their patients, an insurance company
14 and/or PBM may influence not only the cost of the medication, but also the amount that is
15 dispensed to the patient¹. In certain situations, such as when a patient is taking a maintenance
16 medication, the insurer or PBM, may be incentivized to require a 90-day supply to be dispensed,
17 even if a 30-day supply was prescribed.² While this may not be an issue once the patient's
18 medication and dosage are established, it can be a problem for patients and physicians when
19 initially assessing medications, dosages, or making changes to either. When physicians write
20 prescriptions with a set number of refills, some states allow pharmacists to dispense the total
21 amount.² For example, a prescription for a 30-day supply of medication with two refills could
22 result in these pharmacies dispensing the total 90-day supply at once.

23
24 PBM AND INSURER INFLUENCE ON DISPENSING QUANTITIES

25
26 To fully understand the pressures to dispense a 90-day supply it is important to understand the
27 relationship between PBMs, health insurers, and the pharmacies that end up dispensing the
28 medication. PBMs are considered an intermediary that works to manage prescription drug benefits
29 for secondary entities, like health insurers. PBMs have the stated goal of working to lower drug
30 prices through their work negotiating rebates and discounts off the list price of drugs. However, a
31 lack of transparency and regulation into these efforts have yielded confusion and doubt as to if this
32 goal is being met.³ Current efforts by both the Federal Trade Commission (FTC) and Congress are
33 being made to investigate and better understand the innerworkings of PBMs in the process.⁴

34
35 The process of dispensing medication has multiple intersections between PBMs, payers, and
36 pharmacies. PBMs pay pharmacies a drug dispensing fee and negotiate rate prices with the
37 manufacturer, while insurers pay the PBMs fees for administrative work and dispensing fees for

1 medications. For PBMs and payers, these points of intersection may be areas where requiring a
 2 larger quantity of medication to be dispensed is advantageous. For example, when a larger quantity
 3 of medication is being negotiated, it gives the PBM better negotiating power and can lead to lower
 4 negotiated prices or larger rebates. For both PBMs and payers, dispensing greater supplies of
 5 medication can lower the dispensing costs associated with the medication. Additionally, it is not
 6 uncommon for PBMs and/or health insurers to own and operate automatic dispensing facilities,
 7 such as mail order pharmacies, and dispensing greater quantities of a medication can lower
 8 operating costs in these settings as well.⁵ One place of major PBM reform that is promoted by the
 9 National Community Pharmacist Association, is centered around the mandatory use of these PBM
 10 owned mail order pharmacies that often depersonalize the process. This is especially relevant to the
 11 quantity of a medication dispensed as the safeguards of both physicians and pharmacists interacting
 12 with the patient are removed in the automated process used with PBM-owned mail order
 13 pharmacies.⁶

14
 15 Overall, the insertion of payers and PBMs in the process of determining the quantity of a
 16 prescription medication dispensed is opposed both by the AMA and community pharmacists, the
 17 two entities that interact most directly with the patient. While there can be benefits to the
 18 dispensing of a larger supply of medication, especially in the cost savings for the PBM and/or
 19 payer, the decision is one that needs to be made on a patient level and under the supervision and
 20 control of the prescribing physician.

21
 22 **POTENTIAL PATIENT RISKS OF A 90-DAY SUPPLY**

23
 24 Among the key concerns when a patient receives a quantity of a prescription drug that is greater
 25 than what was prescribed include the risk of intentional overdose. While there is not a guarantee
 26 that a physician will be aware of a patient's suicide risk, there is an opportunity for assessment,
 27 both formal and informal, during a medical appointment. Pharmacists' interactions with patients
 28 would not typically include this type of screening process and, thus, they may not be aware of a
 29 potential risk. Unfortunately, even if a risk was recognized, PBMs, who are further removed from
 30 direct patient engagement, may force pharmacists to fill larger quantities without the ability to
 31 apply insurance coverage at lower quantities. Currently, there are strict regulations on the quantity
 32 of controlled substances that can be dispensed as these medications are often seen in suicide
 33 attempts or completions.^{7,8} However, other prescription medications are not regulated at the same
 34 level and may still be used in suicide attempts or completions.^{8,9}

35
 36 A second concern regarding patients receiving quantities of prescription medication greater than
 37 prescribed is the oversupply of medications. Oversupply is a concern with regard to the potential
 38 for increased cost to the patient and patient stockpiling. When a prescription is dispensed at a
 39 greater quantity than prescribed, a patient may not need the full 90 days. For example, if a
 40 medication is new and the physician is working with the patient to establish the correct dosage
 41 there may be a change in the dosage prior to completion of the full 90 days. The oversupply of a
 42 prescription drug can lead to a patient stockpiling a medication, which, even when unintentional,
 43 can be dangerous and should be avoided.¹⁰ In addition to the potential for a medication to be
 44 stockpiled, it is possible that this oversupply could place an undue financial burden on the patient.
 45 For instance, should a patient be prescribed a medication with a substantial co-pay that is only
 46 covered in a 90-day supply, but that prescription is altered before completion of the 90 days, the
 47 patient may be responsible for an additional, expensive co-pay. The cost of prescription
 48 medications in the United States is a major barrier for many to access the care they require and
 49 should be mitigated whenever possible.¹¹

1 POTENTIAL PATIENT BENEFITS OF A 90-DAY SUPPLY

2
3 While there are some substantial potential risks associated with dispensing larger supplies of
4 medication than prescribed, there are some potential benefits as well. When allowed, pharmacists
5 may be inclined or forced to dispense the larger supply due to the financial benefits and improved
6 patient adherence to the medication regimen. Each year, a lack of medication adherence directly
7 relates to approximately 10 percent of all health care spending in the United States⁷. Research has
8 demonstrated that a larger supply of medication has been linked with greater medication adherence,
9 which is especially true in patients who traditionally have the lowest levels of adherence. This
10 improvement in adherence is explained by reduction of barriers and improvement in convenience
11 for the patient. For example, if a patient has difficulty finding transportation to and from the
12 pharmacy, reducing the number of trips may boost adherence. Additionally, patients report greater
13 satisfaction with a greater supply of medication, especially for those who have multiple
14 prescriptions. Most importantly, adherence to medications, particularly medications for chronic
15 diseases like hypertension and diabetes, significantly improves patient outcomes and reduces health
16 care costs.⁷

17
18 In addition to greater medication adherence, there is the added benefit of cost savings with a larger
19 quantity of medication for the pharmacy and the patient. Prescription drug cost reduction is
20 typically centered around a lower distribution cost, negotiated drug cost, and potential rebates.⁵
21 These potential advantages can lead to cost-savings to the patient, as well as a reduction in the time
22 spent obtaining their prescriptions. However, to ensure that patients are receiving lowered costs
23 when appropriate, but not an oversupply of medication, it is important that the decision regarding
24 amounts of dispensed medications remain within the context of the patient-physician relationship.

25
26 RELEVANT AMA POLICY

27
28 The AMA currently has policies that address the dispensing of prescription drugs. The most
29 directly relevant AMA policies on the topic of medication dispensing are Policies [H-120.962](#) and
30 [H-185.942](#). Each of these policies ensure that physicians can specify the appropriate quantity of a
31 prescription drug and that insurers must have a specific process in place when exceptions to the
32 typically dispensed amount needs to be altered due to a medical reason. Policy H-120.962
33 specifically addresses mail order pharmacies and outlines when a 90-day prescription may not be
34 appropriate; during the initialization and dose stabilization of a new medication and when changing
35 the dosage of a long-term medication. Policy H-185.942 outlines AMA support for working with
36 insurers to ensure that there is an exceptions process for patients that may need a higher or lower
37 dispensed amount of a medication due to a medical necessity and supports physician ability to limit
38 quantities of a prescription drug during initialization and dose stabilization of a new medication or
39 if the medication may pose a risk to patients.

40
41 In addition to policies related to the dispensing of prescription medications, the AMA has policy
42 related to limiting the overreach of pharmacists into medical decision-making. Of specific
43 relevance, Policy D-120.934 indicates AMA's intent to prohibit pharmacy actions that are
44 unilateral medical decisions and directs the AMA to implement polices that ensure prescriptions
45 are dispensed by pharmacists as ordered by the physician or prescriber, including the quantity
46 ordered. Policies D-35.981 and D-35.987 more generally establish AMA's opposition to the
47 inappropriate practice of medicine by pharmacists. Policy D-35.981 confronts the "intrusion" of
48 pharmacy into medical practice. Policy D-35.987 outlines the AMA's intent to study, oppose, and
49 educate about inappropriate scope of practice expansions that would allow pharmacists to perform
50 services that constitute the practice of medicine, including opposition to laws that would allow

1 pharmacists to prescribe medications or to dispense medication beyond the expiration date of the
2 original prescription.

3
4 In addition, Policies H-115.967 and H-95.945 both outline the AMA's actions to promote
5 education, tracking, and packaging that prevents addiction, misuse, and harm. Specifically, Policy
6 H-115.967 focuses on introducing packaging for controlled substances that is more functional for
7 patients, improves patient adherence, and reduces the risk for misuse and abuse. Policy H-95.945
8 supports the permanency of and funding for the National All Schedules Prescription Electronic
9 Reporting and state/jurisdiction Prescription Drug Monitoring Programs. Additionally, the policy
10 outlines support for the availability of these data and the education of physicians on how to reduce
11 the misuse of prescription drugs.

12
13 Policies H-120.943 and H-120.952 state the AMA's work to ensure that the dispensed quantity of a
14 prescription drug is adequate for the patient, not overregulated, and not an undue burden on the
15 physician. Policy H-120.943 outlines the requirement for a medication that is dispensed for a
16 month and three-month supply and indicates the AMA's opposition to the arbitrary prescription
17 limits of medication for patients with pain related to cancer or a terminal illness. Similarly, Policy
18 H-120.952 opposes restriction to legitimate and clinically appropriate refills and encourages the
19 implementation of a prescription refill schedule.

20 21 DISCUSSION

22
23 In weighing the potential benefits and risks of dispensing a larger supply of medication, there is no
24 one correct answer for all patients. However, it is clear that physicians and patients should be able
25 to work collaboratively to make the correct choice for each individual patient. Further complicating
26 the issue are direction from PBMs and payers requiring or financially incentivizing the use of
27 certain PBM owned mail order pharmacies that only dispense 90-day supplies of certain
28 medications. These practices can lead to not only confusion and frustration for both physicians and
29 patients, but also can be potentially dangerous and expensive for patients.

30
31 Although research has demonstrated benefits to dispensing 90-day supplies of medications to
32 patients, the Council believes it is essential that the decision as to the quantity of medication
33 dispensed is one that is made within the patient-physician relationship, not by insurers, pharmacies,
34 or PBMs. The Council also believes that the benefits of a 90-day supply are most prevalent for
35 maintenance medications that are stable and address chronic conditions. Although the AMA has
36 policy to ensure that the patient is able to receive the prescribed amount of a medication, as well as
37 policy that opposes the overreach of pharmacist practice, the Council believes that the language of
38 existing policy can be strengthened to ensure that the quantity of a medication dispensed remains a
39 decision made within the patient-physician relationship.

40
41 Therefore, the Council believes that the implementation of clear guidelines for physicians to
42 indicate that a prescription should be dispensed only as written are warranted. These guidelines
43 could follow what have been implemented in states where physicians are able to write "dispense
44 quantity as written," "no change in quantity," or similar language to indicate the necessity of a
45 prescription being dispensed in a specific quantity. Additionally, the Council believes that Policy
46 H-185.942 which ensures that physicians are able to specify the quantity of a prescription
47 dispensed, can be strengthened with the addition of PBMs as a regulated party. Finally, the Council
48 believes that AMA policy on both ensuring the dispensing of adequate amounts of medication
49 without undue burden on the physician or patient and restricting the influence of PBMs and payers
50 are adequate and should be reaffirmed.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 237-A-22, and that the remainder of the report be filed:

- 5
6 1. That our American Medical Association (AMA) support the development and
7 implementation of clear guidelines and mechanisms to indicate that the quantity of a
8 prescription should be dispensed only as written using such language as “dispense quantity
9 as written” or “no change in quantity.” (New HOD Policy)
10
11 2. That our AMA amend Policy H-185.942, to read as follows:
12
13 1. Our AMA supports the protection of the patient-physician relationship from interference
14 by payers and Pharmacy Benefit Managers (PBMs) via various utilization control
15 mechanisms, including medication and testing and treatment supply quantity limits.
16
17 2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity
18 limits for prescription drugs or testing and treatment supplies, an exceptions process must
19 be in place to ensure that patients can access higher or lower quantities of prescription
20 drugs or testing and treatment supplies if medically necessary, and that any such process
21 should place a minimum burden upon patients, physicians and their staff.
22
23 3. Our AMA supports interested state legislative efforts and federal action and will develop
24 model state legislation to ensure that third party payers or PBMs that institute quantity
25 limits for prescription drugs or testing and treatment supplies include an exceptions process
26 so that patients can access higher or lower quantities of prescription drugs or testing and
27 treatment supplies if medically necessary, including provisions such as the following....
28 (Amend AMA Policy)
29
30 3. That our AMA reaffirm Policy H-320.953, which defines the term “medical necessity” as
31 referenced in the suggested amended policy H-185.942 (above) in recommendation two.
32 (Reaffirm AMA Policy)
33
34 4. That our AMA reaffirm Policy H-120.952, which ensures that the quantity of a medication
35 dispensed to patients is of adequate supply, not overregulated, and that receiving the
36 medication is not an undue burden on the patient or the prescribing physician. (Reaffirm
37 HOD Policy)
38
39 5. That our AMA reaffirm Policy D-120.934, which ensures that prescriptions must be filled
40 as ordered, including the quantity, and that PBMs and payers restrict policies that impact
41 patient access to prescription medications. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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Appendix
AMA Policies Recommended for Reaffirmation or Amendment

Policy H-185.942 “Third Party Payer Quantity Limits”

1. Our AMA supports the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
 - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
 - physicians can appeal adverse determinations regarding quantity limitations;
 - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
 - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
 - physicians with specialized qualifications may not be subject to quantity limits;
 - payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
 - payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and
 - physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12; Reaffirmation: I-17)

Policy H-320.953 “Definitions of “Screening” and “Medical Necessity””

- (1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
- (2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term “medical screening examination”; “The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.”
- (3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- (4) Our AMA incorporates its definition of “medical necessity” in relevant AMA advocacy documents, including its “Model Managed Care Services Agreement.” Usage of the term “medical necessity” must be consistent between the medical profession and the insurance industry. Carrier

denials for non-covered services should state so explicitly and not confound this with a determination of lack of “medical necessity”.

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06; Reaffirmed: CMS Rep. 01, A-16)

Policy H-120.952 “Restriction on Prescription Refills”

1. Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (A) restricting refill hours to less than usual pharmacy hours; (B) restricting refills to limited pharmacies rather than all participating pharmacies; (C) restricting refills for chronic medications to a less than 90-day supply; and (D) restricting the date of refill.

2. Our AMA will encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the need for multiple renewal requests and travel barriers for prescription acquisition. (Res. 512, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 801, I-12; Modified: Sub. Res. 719, A-13; Reaffirmed: CMS Rep. 04, A-16)

Policy D-120.934 “Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care”

1. Our AMA will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.

2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.

3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

REPORT 08 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Impact of Integration and Consolidation on Patients and Physicians
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Interim meeting, the Council presented CMS Report 3, which was an informational report that provided background on the issue of health system consolidation. The next report in the Council's ongoing series on this topic is presented here and examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician practice vertical integration on physicians, patients, and local markets. An important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. While this is also a prevalent issue in health care, it is not the focus of this report.

Both horizontally and vertically integrated health care entities may engage in a range of anticompetitive behaviors, including raising prices, excluding rivals, raising their costs, bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts.

This report examines the shared jurisdiction between the FTC and the DOJ in the merger and acquisition process. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

When examining a potential health care merger or acquisition, the FTC focuses on four areas: price effects, clinical quality effects, patient access, and provider wages. While evidence of impacts on health care prices and spending is stronger and more consistent, data on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time.

The Council recommends that the American Medical Association (AMA) continue to monitor the impact of hospital-physician practice integration and hospital-hospital consolidation on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor, as well as the impact of non-compete clauses on physicians. The Council also recommends that the AMA broadly support efforts to collect relevant information on mergers and acquisitions in their state and/or region and work with state attorneys general (AG) to ensure proper review of these transactions before they occur. Finally, the Council recommends that the AMA support and encourage physicians to share their own experiences with mergers and acquisitions with the FTC through their online submission process.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 08-A-23

Subject: Impact of Integration and Consolidation on Patients and Physicians

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

1 At the 2022 Interim meeting, the Council presented CMS Report 3 which was informational and
2 provided background on the broad issue of health system consolidation. Consistent with Policy
3 D-215.984, which requested regular updates, this report examines the impact of horizontal and
4 vertical integration on health care prices and spending, patient access to care, quality of care, and
5 physician wages and labor. This report also includes an overview of the Federal Trade Commission
6 (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a
7 role in preventing anticompetitive behavior and outcomes.

8 9 BACKGROUND

10
11 It is important to distinguish the difference between horizontal integration and vertical integration.
12 A horizontal transaction often refers to a merger, purchase, or acquisition of an entity. Horizontal
13 integration (or consolidation) reflects arrangements between entities that “operate in a similar
14 position along the production process,”¹ meaning that they offer the same services and compete
15 with one another. One hospital acquiring or merging with another hospital would be considered
16 horizontal consolidation. Vertical integration reflects arrangements between entities that “operate at
17 different points along the production process,”² meaning that they do not directly compete with one
18 another. An example of this could be a hospital acquiring a physician practice. For the purposes of
19 this report, hospital-hospital mergers will be referred to as horizontal consolidation, while hospital-
20 physician practice transactions will be referred to as vertical integration, although the latter may
21 also have horizontal aspects if the hospital already owned other physician practices before the
22 transaction. We note that mergers and acquisitions are complex economic issues and recognize that
23 there are many different types of transactions – and nuances within each of those transactions – but
24 the Council has chosen to focus on these two types of transactions for this report.³

25 26 HOSPITAL-PHYSICIAN INTEGRATION AND HOSPITAL-HOSPITAL CONSOLIDATION

27
28 This report specifically addresses the impact of hospital-hospital horizontal consolidation and
29 hospital-physician vertical integration on physicians, patients, and local markets. At the onset, an
30 important distinction to make is that private equity investment in a hospital or a physician practice
31 is not the same as vertical or horizontal integration, but instead is an issue of a change in
32 ownership. Recently there has also been an uptick in the number of physicians employed by
33 corporate-owned or publicly traded practices (i.e., CVS, Amazon). While these are also prevalent
34 issues in health care, they are not the focus of this report, and we would encourage members to
35 reference CMS Report 2-I-22, Corporate Practice of Medicine, for more information on this topic.

36
37 In the United States, 90 percent of Metropolitan Statistical Areas (MSAs) are considered
38 concentrated for hospital services, and 65 percent of MSAs are considered concentrated for

1 outpatient specialty care. Research suggests that the impact of hospital-hospital horizontal
 2 consolidation includes higher prices for services, higher insurance premiums and consumer cost
 3 sharing, lack of quality gains and decrements in the patient experience. Hospital markets are not the
 4 only component of care delivery that is concentrated, with an estimated 39 percent of MSAs
 5 considered concentrated for primary care physicians and 65 percent for specialty care. Rising
 6 prices and reduced choice for patients are often the outcome following hospital-hospital
 7 consolidation and/or hospital-physician integration.⁴

8
 9 Vertically integrated health care entities may engage in a range of potentially anticompetitive
 10 behaviors, including raising prices, excluding rivals (or raising their costs), bargaining with health
 11 plans to demand higher prices for affiliated providers, and including anticompetitive terms in their
 12 contracts (such as restrictive covenants on employed physicians).⁵

13
 14 Although billions of dollars in COVID-19 federal relief funds have been dispersed across the
 15 health care industry, a majority of the funding has gone to large hospital systems. This has left
 16 many independent physician practices to suffer reductions in patient visits and revenues, making
 17 them vulnerable to hospital-physician practice vertical integration.⁶ The risks such transactions
 18 pose to patients include higher prices, increased spending, and reduced choice. The economic
 19 impact of the COVID-19 pandemic on independent physician practices has accelerated pressure for
 20 vertical integration between hospitals and physician practices. Remaining independent physician
 21 practices are under financial strain due to the economic impact of the pandemic, and even those
 22 who previously resisted acquisition face new pressure to sell to large hospital systems or private
 23 equity investors for financial stability and survival.⁷

24
 25 Data from the AMA's 2022 Physician Practice Benchmark Survey indicates that physicians in
 26 practices wholly owned by physicians have decreased from 60 percent to 47 percent from 2012 to
 27 2022. Conversely, physicians in practices wholly or jointly owned by hospitals have increased from
 28 23 percent to 31 percent over the same time period. In 2022, ten percent of physicians were directly
 29 employed by or contracting with a hospital (up from six percent in 2012). While there are many
 30 factors driving these changes, it is important to note the trends in physician practice ownership over
 31 the last decade.

32
 33 *Impact on Health Care Prices and Costs*

34
 35 Evidence suggests that hospital-physician integration leads to higher health care prices – including
 36 higher hospital prices, percent higher physician prices, and 10-20 percent higher total expenditures
 37 per patient.⁸ Prices have been shown to increase in hospitals following such integration. The harms
 38 of hospital-hospital consolidation also include higher prices for patients.⁹

39
 40 There are several ways hospital-physician integration can increase health care prices. These include
 41 the addition of facility fees that hospitals can charge for outpatient services provided by acquired
 42 physicians, increased market power when negotiating with payers, and direct referrals of captive
 43 physician practices to a greater extent than independent physicians not related to the hospital
 44 system, which could increase referrals to higher-cost providers and services.¹⁰

45
 46 Generally, prices will ascend to the level a market will pay. If a certain entity has market power,
 47 prices can rise to offset rising expenses and declining patient volume.¹¹ According to a paper
 48 prepared for Congress by economists Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg
 49 addressing horizontal consolidation of hospitals, hospitals without local competitors are estimated
 50 to have prices nearly 16 percent higher on average than hospitals with four or more competitors,
 51 which is a difference of nearly \$2,000 per admission.¹² A large body of economic literature

1 summarized by Gaynor in 2021 found substantial increases in hospital prices as a result of hospital-
 2 hospital consolidation. Increases are widely seen, but vary significantly, from three percent to 65
 3 percent. A 2019 study by Cooper et al., found an average price increase of six percent as a result of
 4 hospital mergers, and Arnold and Whaley (2020) found an average price increase of 3.9
 5 percent.^{13,14,15,16}

6
 7 *Impact on Patient Access to Care*

8
 9 Current data on the impact hospital-physician integration has on patient access to care is limited,
 10 making this issue one to continue to monitor. Nonetheless, the Council is concerned that vertical
 11 integration may lead to a more difficult environment for the remaining physician-owned practices
 12 in terms of competition and referral steering. To the extent that consolidation may narrow networks
 13 or make areas harder for new practices to enter, this may have the effect of reducing patient choice.
 14 Thus far, there have only been two peer reviewed studies that examined the effect of vertical
 15 integration of hospitals and physician practices on access to care.¹⁷

16
 17 Increased vertical integration in health care could also potentially reduce consumer choice by
 18 creating larger, exclusive networks and driving patients and health plans to pay higher prices. Data
 19 does not yet indicate that these higher costs and reductions in choice among independent providers
 20 are offset by higher quality or efficiency from improved care coordination. As vertical integration
 21 continues to occur, states are increasingly searching for ways to curb the rising costs and loss of
 22 choices.¹⁸

23
 24 Data on the impact of hospital-hospital consolidation are also limited. There have been two recent
 25 studies that examine the effect of consolidation on rural hospitals specifically, but there is no
 26 conclusive data on other markets. Henke et al., (2021) found that merged rural hospitals were more
 27 likely than independent hospitals to eliminate maternal, neonatal, and surgical care services. There
 28 was also a decrease in the number of mental health and substance use disorder-related stays.
 29 However, there is an important caveat to consider: without a merger a rural hospital may be forced
 30 to close and even limited services would be eliminated from a community entirely.^{19,20} Similarly,
 31 O’Hanlon et al. (2019), found that rural hospitals that became affiliated with integrated health
 32 systems experienced a significant reduction in diagnostic imaging technologies, obstetric and
 33 primary service availability, and outpatient nonemergency visits.^{21,22} While these results could be
 34 an early indication of a trend following hospital-hospital consolidation, more evidence is needed
 35 before conclusions can be drawn. For more information on Rural Health Care, please see CMS
 36 Report 9-A-23.

37
 38 *Impact on Quality of Care*

39
 40 Empirical studies examining the effect of vertical integration of hospitals and physician practices
 41 on quality of care showed mixed effects.²³ Findings from two studies suggest no effects on quality
 42 of care while two other studies using data from the American Hospital Association (AHA) found
 43 mixed effects. The findings of the studies using AHA data suggest that organizations that are fully
 44 clinically integrated had small positive effects on some measures of quality while arrangements
 45 that were not fully clinically integrated had no effect on the quality of care.²⁴

46
 47 Studies on hospital-hospital consolidation on quality of care are also inconclusive. Some have
 48 found no change in the quality of care while others have shown a decrease in the quality of care. A
 49 2020 study by Beaulieu et al., examined 246 hospital mergers between 2007 and 2016 and found
 50 that relative to similar hospitals that did not experience a merger, hospitals acquired in a merger
 51 saw no significant differential change in 30-day readmission rate and 30-day mortality rate in the

1 Medicare population. Interestingly, patient experience measures declined. However, it is important
 2 to note that the association between mergers and declines in patient experience does not necessarily
 3 imply causality; other factors may be in play. Therefore, one should be cautious in the
 4 interpretation of those findings. Additionally, it is important to note that data on the impact of
 5 integration and consolidation on quality is meaningless without clearly defined quality metrics.^{25,26}
 6

7 *Impact on Physicians*
 8

9 The AMA has long supported physician-led care teams and physician supervision of non-
 10 physicians. When either hospital-physician integration or hospital-hospital consolidation occurs,
 11 motives may shift to focus on profit and physicians may be replaced with non-physician
 12 practitioners in an effort to achieve cost savings. However, emerging data suggests that a provider
 13 mix (i.e., the number of physicians vs. non-physician practitioners) shift occurs in the years
 14 following a merger or acquisition, with physicians being replaced by non-physicians to lower costs
 15 and increase profits. Emerging data suggest shifting more patients to non-physician practitioners
 16 could ultimately increase cost and simultaneously decrease quality of care.
 17

18 Available data from recent studies on the impact of vertical integration on health care wages and
 19 labor supply are limited, insufficient, and ultimately, inconclusive. In terms of compensation, a
 20 2021 study by Whaley, Arnold, et.al., found that ownership of a physician’s practice by a hospital
 21 or health system was associated with lower income among physicians overall.^{27,28} As with the data
 22 on patient access to care, further evidence is needed to conclusively determine the impact of
 23 hospital-physician integration on health care wages and labor market changes.²⁹ There are even
 24 fewer studies available on the effect of hospital-hospital consolidation on physician wages. There is
 25 some evidence that nurses’ and pharmacists’ wages decrease following a hospital merger, but there
 26 is no significant data on the impact on physician wages.³⁰
 27

28 On January 5, 2023, the FTC proposed a rule to ban future noncompete clauses and invalidate
 29 existing agreements. In the proposed rule, the FTC stated that noncompete clauses depress worker
 30 wages and limit competition. Typically, a noncompete clause would bar a physician from
 31 practicing medicine for a certain period of time within a defined geographic area or specific mile
 32 radius. FTC regulators argue that noncompete clauses stifle competition and cause price increases
 33 for patients in markets that are highly concentrated, as many health care markets are in the United
 34 States. Critics question whether this proposed rule is within the purview of the FTC. One of those
 35 critics is the AHA, which stated in its comments that “the proposed regulation errs by seeking to
 36 create a one-size-fits-all rule for all employees across all industries, especially because Congress
 37 has not granted the FTC the authority to act in such a sweeping manner. Even if the FTC had the
 38 legal authority to issue this proposed rule, now is not the time to upend the health care labor
 39 markets with a rule like this.”³¹ The public comment period for this proposed rule was open until
 40 April 19, 2023.³² At the time of writing, AMA comments were still being prepared. The Council
 41 will continue to monitor the issue and its impact on physicians.
 42

43 **OVERSIGHT AND ENFORCEMENT**
 44

45 There is shared jurisdiction between the FTC and the DOJ when reviewing mergers and
 46 acquisitions. Typically, the FTC reviews mergers between providers (hospitals, physician groups,
 47 etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive
 48 control over criminal enforcement.
 49

50 The FTC, DOJ, and private parties suffering antitrust injury use the Clayton Act, the Sherman Act,
 51 and in the case of the FTC, the FTC Act to enforce antitrust laws. The Sherman Act of 1890 is the

1 US antitrust law which prescribes the rule of free competition among those engaged in commerce.
2 Importantly, the Sherman Act does not prohibit every restraint of trade, only those that are
3 unreasonable. Certain acts are considered so harmful to competition that they are almost always
4 illegal under the Sherman Act. These include plain arrangements among competing individuals or
5 businesses to fix prices, divide markets or rig bids. The Clayton Act of 1914 addresses specific
6 practices that are not directly addressed by the Sherman Act, including mergers. Specifically,
7 Section 7 of the Clayton Act prohibits mergers and acquisitions where the effect “may be
8 substantially to lessen competition or tend to create a monopoly.” The Clayton Act was amended in
9 1976 by the Hart-Scott-Rodino Act, which purposely exempts small transactions (valued at less
10 than \$111.4 million as of February 27, 2023) from pre-merger notification to not increase the
11 regulatory burden on small enterprises in addition to avoiding generating unnecessary transactions
12 for FTC staff to review. This threshold is adjusted annually and results in many health system,
13 hospital and/or physician mergers proceeding without FTC and/or DOJ review.
14

15 Another hurdle contributing to increases in consolidation in recent years is FTC constraints on its
16 ability to enforce antitrust laws in the not-for-profit health care sector. Vertical integration is
17 particularly challenging for the FTC to monitor because it is often the result of hospitals acquiring
18 many smaller practices and each of those transactions may fall under the \$111.4 million threshold
19 of having to notify the FTC. Additionally, the FTC has raised concerns about its inability to
20 enforce antitrust rules on most non-profit organizations, including most non-profit hospitals. The
21 FTC can only enforce Section 5 of the FTC Act against persons, partnerships, or corporations.
22 “Corporations” are defined as those entities organized to carry on business for-profit. Accordingly,
23 the FTC Act does not give the FTC the ability to enforce Section 5 against most non-profit entities,
24 which constitute the vast majority of hospitals.
25

26 The Council met with representatives from the FTC to discuss the process of reviewing mergers
27 and acquisitions. When examining a potential merger or acquisition, FTC staff focus on four areas:
28 price effects, clinical quality effects, patient access, and provider wages. When a proposed merger
29 filing comes in, FTC staff have 30 days to decide whether or not to issue a challenge. If a challenge
30 is issued, the deal is prohibited from closing until further investigations are completed. During
31 these investigations, the merging entities may negotiate further to receive the approval of the FTC,
32 or the case could go to court. Alternatively, the two merging entities may decide to abandon the
33 deal altogether.
34

35 The representatives from FTC stressed the importance of physicians as the best advocates for
36 patients, especially regarding mergers between health care facilities. FTC staff time is limited,
37 especially given the quick timeline in which the FTC must decide whether or not to challenge a
38 merger, so input from impacted communities is helpful in flagging potential concerns. Information
39 shared by physicians is used by the FTC when evaluating potential mergers and acquisitions and is
40 immensely helpful in providing a voice for physicians and patients who would be impacted most.
41 The FTC encourages physicians to share their experience via email to the following address which
42 is monitored regularly by staff: antitrust@ftc.gov. Physicians are encouraged to work with their
43 state medical associations and/or state attorneys general (AG) to report mergers or acquisitions that
44 fall below the FTC threshold for review. Alternatively, physicians (or any member of the public)
45 are welcome to report potential antitrust violations to the FTC here:
46 <https://www.ftc.gov/enforcement/report-antitrust-violation>.
47

48 In 2020, the FTC and DOJ published, and the FTC subsequently withdrew, revised Vertical Merger
49 Guidelines. After withdrawing the guidelines because they cited “unsound economic theories” the
50 FTC stated that it will continue working with the DOJ Antitrust Division to update merger
51 guidance to better reflect market realities. Updated Vertical Merger Guidelines are expected in

1 2023. Physicians are strongly encouraged to review these guidelines when they are available and
 2 provide comments during the public comment period.

3
 4 States also have a critical role in oversight because vertical integration transactions often fly under
 5 the radar of federal antitrust agencies because they tend to be too small in size to be reported under
 6 the Hart-Scott-Rodino Act, which has a threshold of \$111.4 million in 2023. States can be
 7 proactive in the merger process by data gathering using all-payer claims databases, pre-transaction
 8 review and approval, oversight of vertically integrated entities, and controlling outpatient costs
 9 (i.e., restrictions on facility fees to counteract private-equity based acquisitions).³³ States can study
 10 the price, utilization, or referral effects of vertical transactions; detect targets for enforcement;
 11 provide oversight of vertically integrated entities; plan and assess the need for new and additional
 12 services; quantify the amount of facility fees charged; enforce compliance with surprise out-of-
 13 network billing rules; or implement global budgets. Many states already require hospitals to notify
 14 state officials of proposed mergers or acquisitions; however, states could expand the requirement to
 15 transactions involving physicians. One example of this is in Washington state, which passed a law
 16 in 2019 to require notification to the state AG of health care transactions, including those involving
 17 “provider organizations,” below the Hart-Scott-Rodino threshold. Connecticut requires 30-day
 18 notice] to the AG and the head of the Office of Health Strategy of any proposed transaction
 19 involving a physician practice of eight or more physicians. In Massachusetts, all provider
 20 organizations must provide the AG, the Health Policy Commission, and the Center for Health
 21 Information Analysis with a 60-day notice of any mergers, acquisitions, or affiliations. Unlike the
 22 FTC, state AGs can regulate transactions involving nonprofit entities.³⁴

23
 24 **AMA POLICY**

25
 26 The AMA has long-standing policy emphasizing the importance of competition in health care
 27 markets and striving to protect physician autonomy and well-being before, during, and after health
 28 care mergers and acquisitions (H-215.960, H-215.969).

29
 30 Policy D-215.984 states that the AMA will study nationwide health system and hospital
 31 consolidation in order to assist policymakers and the federal government in assessing health care
 32 consolidation for the benefit of patients and physicians who face an existential threat from health
 33 care consolidation; and regularly review and report back on these issues to keep the House of
 34 Delegates apprised on the relevant changes that may impact the practice of medicine. Furthermore,
 35 Policy D-383.980 affirms that the AMA will study the potential effects of monopolistic activity by
 36 health care entities that may have a majority of market share in a region on the patient-doctor
 37 relationship; and develop an action plan for legislative and regulatory advocacy to achieve a more
 38 vigorous application of antitrust laws to protect physician practices which are confronted with
 39 potentially monopolistic activity by health care entities.

40
 41 **DISCUSSION**

42
 43 In general, empirical evidence is emerging on the impact of vertical integration on patients,
 44 physicians, and health care. While evidence of impacts on health care prices and spending is
 45 stronger and more consistent, evidence on effects on patient access, changes in quality outcomes,
 46 and physician wages and workforce are insufficient to draw meaningful conclusions at this time.
 47 However, research continues to be conducted, such as on the effects of hospital-physician
 48 integration on quality as well as on the potential mechanisms underlying its effects on prices and
 49 spending, especially as this and other acquisitions of physician practices become more common
 50 The Council will continue to stay informed of new data and research and will address future policy
 51 recommendations as needed.

1 As data continue to be collected and vertical integration involving physicians continues to occur
2 regularly, physicians should work with their state medical associations who in turn should work
3 with their state attorneys general and state legislators to address these transactions. Potential state
4 policy solutions include notification of health care transactions to public officials and pre-
5 transaction review by states for those mergers and acquisitions that fall under the FTC/DOJ review
6 threshold. Flagging these transactions will allow time to review the impacts each would have on
7 the patients and physicians within a community and broader market concentration effects in the
8 impacted areas.

9
10 When meeting with representatives from the FTC, it was repeatedly stressed that the most
11 important thing physicians can do regarding concerning mergers and acquisitions is to share
12 individual perspectives on how consolidation has impacted their practice, their patients, and their
13 community. When published, physicians should review the FTC's update to the Vertical Merger
14 Guidelines and provide feedback during the public comment period.

15
16 The Council believes that changes in provider mix and wages following a merger or acquisition is
17 an issue that should be monitored closely but that peer-reviewed data on the topic is not yet robust
18 enough for policy recommendations at this time. Similarly, the Council believes that mergers or
19 acquisitions may impact access and quality of care and will continue to monitor this data as it
20 becomes available.

21
22 The recommendations presented in this report are more actionable and supersede the
23 recommendations in Policy D-215.984, Health System Consolidation. Thus, we recommend that
24 policy be rescinded with the adoption of the following recommendations.

25 RECOMMENDATIONS

26
27
28 The Council on Medical Service recommends that the following recommendations be adopted, and
29 the remainder of the report be filed:

- 30
31 1. That our American Medical Association (AMA) continue to monitor the impact of
32 hospital-physician practice and hospital-hospital mergers and acquisitions on health care
33 prices and spending, patient access to care, potential changes in patient quality outcomes,
34 and physician wages and labor. (New HOD Policy)
- 35
36 2. That our AMA continue to monitor how provider mix may change following mergers and
37 acquisitions and how non-compete clauses may impact patients and physicians. (New
38 HOD Policy)
- 39
40 3. That our AMA broadly support efforts to collect relevant information regarding hospital-
41 physician practice and hospital-hospital mergers and acquisitions in states or regions that
42 may fall below the Federal Trade Commission(FTC)/Department of Justice review
43 threshold. (New HOD Policy)
- 44
45 4. That our AMA encourage state and local medical associations, state specialty societies, and
46 physicians to contact their state attorney general with concerns of anticompetitive behavior.
47 (New HOD Policy)

- 1 5. That our AMA encourage physicians to share their experiences with mergers and
2 acquisitions, such as those between hospitals and/or those between hospitals and physician
3 practices, with the FTC via their online submission form. (New HOD Policy)
4
5 6. That our AMA rescind policy D-215.984. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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REPORT 09 OF THE COUNCIL ON MEDICAL SERVICES (A-23)
Federally Qualified Health Centers and Rural Health Care
(Reference Committee G)

EXECUTIVE SUMMARY

This report, initiated by the Council, provides information and background on Federally Qualified Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report discusses the importance of these centers to providing essential health care and the physician experience for those who work in these settings. The report also details relevant American Medical Association (AMA) policy and provides recommendations to ensure that these clinics are maintained and that physicians are able to practice without undue burden.

The Council understands that FQHCs and similar clinics serving areas of medical need are a key aspect of the AMA's existing advocacy to reduce health care disparities in rural communities through increasing access to health care services. The AMA has a robust body of policy and advocacy efforts supporting general efforts to improve health care in rural communities. To fully support the health care services provided in these clinic settings, the Council discusses the importance of maintaining funding streams, reducing physician administrative burden, and ensuring that all care provided is overseen by a physician. In order to maintain the feasibility of FQHCs and similar health centers, it is important that a continued investment be made by the federal government as FQHCs receive a majority of funding through grants from the federal government. These grants allow these health services to be delivered to communities that would otherwise face significant barriers to access. In addition to ongoing funding, it is important that the regulating bodies of these health centers ensure that the certification and operating regulations do not place undue burdens on the physicians practicing in these settings. Physicians nationwide are faced with significant administrative work and those practicing in settings like FQHCs may face even more daunting administrative tasks. Finally, to ensure that these underserved communities receive high quality health care, it is important that all care be overseen by physicians. Oversight regarding physician supervision must be maintained to guarantee that all communities served by FQHCs, and similar health centers receive high-quality health care.

The Council recommends adoption of two new policies, one advocating for clear certification requirements and other policies that reduce the administrative burden on physicians practicing in FQHCs, and a second supporting federal funding to maintain costs associated with operating these health centers. In addition to these two new policies, the Council recommends reaffirming existing AMA policy that supports the implementation of programs to improve rural communities' health, H-465.994, advocates for the authorization of Chronic Care Management reimbursement for physicians, D-390.923, and limits the scope of practice for nonphysician providers without supervision of a physician, H-160.947 and H-35.965.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 09-A-23

Subject: Federally Qualified Health Centers and Rural Health Care

Presented by: Lynn Jeffers, MD, MBA Chair

Referred to: Reference Committee G

1 Adequately addressing the issues that contribute to poor health outcomes and significant disparities
2 for those who live in rural communities continues to be challenging. Approximately 14 percent of
3 Americans live in a rural area, representing approximately 46 million people.¹ The health
4 disparities for rural Americans are quite stark, as these communities tend to be poorer, older,
5 sicker, and die at a 50 percent higher rate from unintentional injury.² One contributing factor to
6 these disparities is the lack of accessible health care facilities and physicians. Approximately 66
7 percent of all Primary Care Health Professional Shortage Areas are in rural communities,
8 indicating a disproportionately high lack of access to care³. Additionally, those in rural areas are
9 geographically further from hospitals and physicians, increasing barriers to access care³. Although
10 the American Medical Association (AMA) has robust existing policy regarding improving the
11 health of rural America, there is limited policy directly related to the centers that serve these
12 populations.

13
14 This report, initiated by the Council, provides information and background on Federally Qualified
15 Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report
16 discusses the importance of these centers to providing essential health care and the physician
17 experience for those who work in these settings. The report also details relevant AMA policy and
18 provides recommendations to ensure that these clinics are funded adequately and that physicians
19 are able to practice without undue burden.

20
21 **BACKGROUND**

22
23 Although rural communities are often woefully underserved, FQHCs and Rural Health Clinics
24 (RHCs) are two types of practices working to bring additional care to these communities. While
25 FQHCs do not exclusively serve rural communities, many do serve these areas. FQHCs are health
26 centers that serve communities, regardless of population density, that are designated health care
27 shortage areas. These clinics are unique in that they not only provide medical care services, but
28 also wraparound and social services. RHCs are clinics that serve designated health care shortage
29 areas that are also considered rural. These clinics provide health care services to their communities,
30 and may, but are not required to, provide social support services. FQHCs and RHCs are similar in
31 many ways but do have distinct differences with RHCs only serving rural communities and FQHCs
32 providing services beyond the traditional health care paradigm. Each of these centers work to
33 provide health care to communities that are in desperate need and, in turn, help to mitigate health
34 care disparities.

Federally Qualified Health Centers

As previously noted, FQHCs are health care centers that provide health care services to rural or urban shortage areas. FQHCs are often the last line of care for individuals who otherwise may go without health care services. These practices are a central location for patients to receive coordinated preventive care and disease management. FQHCs provide medical services and are often able to support patients in accessing dental, social, and mental health services. These centers are vital for the communities they serve by providing care to approximately 30 million people in over 1,400 locations across the country.³ Not only are the communities served by FQHCs often underserved, but they are also often underinsured. Approximately 59 percent of patients at FQHCs are insured publicly and 20 percent are uninsured.^{3,4} These centers are vital in rural communities, with nearly half (45 percent) of all centers serving rural communities where they are, if not the only, one of very few sources of health care services.⁴

These health centers were originally created in 1965 by President Lyndon B. Johnson as an element of his administration's "War on Poverty." These centers were initially called community health centers and operated in a semi-permanent capacity for about a decade. In 1975, these health centers were officially authorized as a permanent program with their incorporation in section 330 of the Public Health Services (PHS) Act. After gaining permanency, the program continued to receive bipartisan support and was continually funded by Congress. In the late 1980s and early 1990s, FQHCs were established as a part of Medicare and Medicaid and were given a \$150 million increase in funding. The following decade brought additional funding increases and reauthorization for FQHCs via efforts by Congress and the Administration. In 2009, \$2 billion was invested in FQHCs through the reauthorization of Children's Health Insurance Program and the American Recovery and Reinvestment Act. An additional funding increase was earmarked in 2011 with the passage of the Affordable Care Act (ACA). However, in the same year a significant budget deficit tempered the initially indicated \$11 billion investment and slowed the expansion of FQHCs. Over the next decade, FQHCs continued to receive funding through reauthorizations and, both directly and indirectly, the implementation of the ACA in 2014. More recently, FQHCs faced significant challenges, as did all of health care, in battling the COVID-19 pandemic. In 2021, the American Rescue Plan was enacted and FQHCs received approximately \$7.6 billion through a variety of different programs.⁵ Notably, FQHCs provided care to 30 million Americans in 2021, indicating their vital place in the landscape of American health care.

In practice, FQHCs are diverse in the services they provide to their patients, with some providing expanded services like mental and behavioral health, but at the core they all meet the basic definition of providing at least primary care services to rural or urban shortage areas. Within these types of practices, clinics fall under one of three categories, a health center program grantee, a "look-alike" program, or an Outpatient Tribal facility. Health center program grantees are what are traditionally referred to as an FQHC. Along with meeting a host of eligibility requirements, in order to receive this designation, the center must receive a grant under section 330 of the PHS Act. FQHC "look-alike" clinics are those that meet many of the same eligibility requirements as the aforementioned health center program grantees, but do not receive grants or funding from section 330 of the PHS Act. Finally, Outpatient Tribal facilities are similar, in that they meet many of the same requirements as a PHS Act granted FQHC; however, they are operated by a tribe, tribal organization, or urban Indian organization. These clinics are funded through either the Indian Self-Determination Act or Title V of the Indian Health Improvement Act. In specific circumstances these clinics are able to be grandfathered in and may not meet each of the eligibility requirements of FQHCs or "look-alikes".⁶ In the remainder of this report the use of the term FQHC will be inclusive of each of these three types of clinics, unless specifically distinguished. Clinics that are classified as FQHCs serve a wide variety of patients and can be seen across the country referred to

1 as organizations like, Community Health Centers, Migrant Health Centers, Health Care for the
2 Homeless Health Centers, and Public Housing Primary Care Centers.⁶

3
4 In order to be designated a FQHC, a center must meet a multitude of practice requirements.
5 Specifically, care must be provided by a physician, nurse practitioner (NP), physician assistant
6 (PA), certified nurse midwife (CNM), clinical psychologist, clinical social worker, or a certified
7 diabetes self-management training/medical nutrition therapy provider. FQHCs must be under the
8 medical direction of a physician, but each of the previously mentioned nonphysician practitioners
9 are able to independently see patients. When seeing a patient, the visit must be deemed either
10 medically necessary or a qualified preventive health visit. Visits generally occur at the health center
11 but may take place in the patient's residence if the patient is home-bound.⁶ Traditionally, these
12 visits were required to occur in person and face-to-face, however during the COVID-19 Public
13 Health Emergency, exceptions were made for increased telehealth visits. These exceptions have
14 been extended beyond the end of the health emergency and will allow for practitioners to continue
15 to see some patients virtually.

16
17 While FQHCs provide a diverse range of services that vary from clinic to clinic, there are a core set
18 of services that must be offered in order to receive a FQHC certification. Required services include
19 primary health services like family medicine, internal medicine, pediatric, and obstetrics and
20 gynecology care. FQHCs are required to provide diagnostic lab services, preventive health
21 services, emergency medical services, and referrals. FQHCs are also required to provide dental
22 screenings to determine if further dental care is needed and while some may have an on-site dentist,
23 full dental care is not a requirement. Additionally, FQHCs are required to provide supplemental
24 services to enable access to care, like transportation, and community education. While not required,
25 FQHCs may also provide care including pharmaceutical services (e.g., pharmacies and/or drug
26 monitoring), behavioral and mental health services, environmental health services, screening and
27 control of infectious diseases, and/or injury prevention programs.⁶ In short, the medical services
28 provided by an FQHC are designed to allow for a "one stop shop" mentality where patients are able
29 to receive care for a variety of needs.

30
31 In addition to the medically centered requirements of an FQHC, there are also more administrative
32 requirements that must be met. These clinics must demonstrate effective procedures for tracking,
33 compiling, and reporting operating costs and patterns of service use as well as the availability,
34 accessibility, and acceptability of services offered. These records should be provided to the
35 governing body upon request. Additionally, the FQHC must complete and file an annual
36 independent financial audit with the Secretary of the Department of Health and Human Services.
37 Regarding payment, FQHCs must have a contracted agreement with the state for those who are
38 eligible for state insurance plans and encourage patients to participate in any insurance plan for
39 which they are eligible. These centers are also responsible for collecting appropriate payment from
40 patients through an established sliding scale fee/payment plan. Finally, they must ensure that no
41 patient is turned away from receiving services due to the lack of ability to pay.⁶

42
43 FQHC governance boards must be comprised of a majority (51 percent+) of individuals who
44 receive care at the clinic, and must meet at least once a month. Additional ongoing quality
45 improvement processes must be continuous and include both clinical services and management
46 operations. Additionally, FQHCs must have established continuing referral relationships with at
47 least one hospital and must demonstrate continued efforts to establish and maintain relationships
48 with other health care providers in the area.⁶

49
50 Any patient can be served at an FQHC, regardless of insurance status or ability to pay. While some
51 FQHCs have a more specified focus, for example a migrant population, there is no restriction on

1 who they are able to provide care for. To ensure that the services offered are geographically
 2 accessible, clinics must regularly review the size of their catchment area and adjust if needed.
 3 Whenever possible, these boundaries should conform with existing local boundaries and work to
 4 eliminate any geographical barriers. FQHCs must operate in an area that has been designated as a
 5 Medically Underserved Area (MUA) or with a population that has been designated a medically
 6 underserved population. Should the clinic operate in an area in which a “substantial portion” of the
 7 community are limited-English speakers, there are specific cultural and language requirements that
 8 must be met. Clinics in these areas must ensure that services are provided in the language and
 9 cultural context that is appropriate for the community. Additionally, the clinic must employ at least
 10 one staff member who is fluent in the language dominant in the community and English in order to
 11 provide assistance in bridging cultural or linguistic differences.⁶
 12

13 The COVID-19 pandemic and subsequent vaccination campaign highlighted the importance of
 14 FQHCs in delivering care to those who are underserved, underrepresented, and underinsured. The
 15 Office of the Assistant Secretary for Planning and Evaluation’s Office of Health Policy’s research
 16 report investigating the barriers and facilitators in COVID-19 vaccine outreach indicated the
 17 widespread success of FQHCs in delivering high rates of vaccination in the communities they
 18 serve. Specifically, 62 percent of FQHCs held vaccination events or mobile clinics in their
 19 communities, distributing 14+ million doses of the vaccine to communities. Importantly, these
 20 FQHCs were not only successful in vaccinating their communities, but 66 percent of vaccinations
 21 were given to people of color, supporting work to decrease health disparities.⁷ In a more specific
 22 example, an FQHC, Proteus, serving primarily H2-A visa workers in Iowa, Nebraska, and Indiana,
 23 set up an innovative program to mitigate the spread of COVID-19. In a non-COVID year the
 24 FQHC provides these farm workers with preventive health care and training on topics like heat
 25 stress and pesticide safety. When the pandemic arose, this model was modified to include infection
 26 mitigation training for the workers and farm owners, COVID testing, providing personal protective
 27 equipment, housing, virtual town halls, and contact tracing. As most of the H2-A visa workers were
 28 Spanish-speaking, this work was all done in a bilingual and culturally responsive fashion. This
 29 program was able to mitigate the spread of COVID while the workers were in the United States,
 30 when they went to their home country, and when they returned to the United States for the
 31 subsequent agricultural season.⁸
 32

33 However, the success of FQHCs providing care to underserved communities is not limited to
 34 COVID. FQHCs across the country provide care to individuals who are in underserved
 35 communities, with 62 percent of patients reporting being a person of color. One specific example is
 36 a FQHC, Dartmouth Geisel Migrant Health Center, that serves primarily Latino patients in the
 37 Northeast United States. It was found that the work done by this FQHC, especially around care
 38 coordination and interpreter services, improved the access to care for the community they served.⁹
 39 These examples demonstrate the power of FQHCs to support communities in not only times of
 40 crisis, like a pandemic, but in everyday health care needs. These centers are vital to providing
 41 health care services to the communities they serve.
 42

43 Rural Health Clinics

44
 45 While RHCs are similar to FQHCs in many ways, there are some key differences. Most
 46 significantly, RHCs only serve rural areas and populations. Similar to FQHCs, RHCs can vary in
 47 type, from independent, hospital-based, or provider-based centers. These clinics are designed to
 48 increase the accessibility of primary care in areas that are underserved due to their rural status.^{10,11}
 49

50 As a point of clarification, although RHCs and rural hospitals may sound similar in name, they are
 51 two separate types of practice. They face distinct differences in financial support, eligibility, and

1 operating requirements. To avoid confusion, rural hospitals will not be included in the current
2 report. A recent report from the Council (Council on Medical Service Report 9-J-21) addressed
3 rural hospitals.

4
5 RHC services are provided by a physician, NP, PA, or CNM and must be under the medical
6 direction of a physician. RHCs are required to have a NP, PA, or CNM providing care services at
7 least half of the time the center is open. These centers are required to provide primary care and
8 routine diagnostic and lab services and, while not required, may provide other types of services
9 such as Transitional Care Management, General Behavioral Health Integration, Chronic Care
10 Management, Principal Care Management, and Psychiatric Collaborative Care Management.
11 Although these clinics are able to provide behavioral and mental health services, they cannot be
12 designated as a rehabilitation agency or a primarily mental disease treatment facility. Patient visits
13 follow very similar requirements as an FQHC in that they must be medically necessary or a
14 qualified preventive health visit and can take place at the center, the patient's home, a skilled
15 nursing facility, or hospice. Visits are not able to take place in an inpatient or outpatient hospital
16 department. Similar to FQHCs, visits were historically required to be in person, but the COVID-19
17 pandemic allowed for telehealth exceptions that have now been extended beyond the Public Health
18 Emergency.^{7,8}

19
20 In order to meet the administrative requirements of RHC certification, centers must file annual cost
21 reports that include payment rates, reconcile interim payments, graduate medical education
22 adjustments, bad debt, and administrative payments. Payment is primarily made through a bundled
23 All-Inclusive Rate (AIR) that is determined for all qualified primary and preventive care services.
24 Dependent upon the patient's insurance status, a co-pay may be applied to the services. For
25 example, patients with Part B Medicare coverage would pay for 20 percent of the AIR once their
26 deductible is met. These centers must also maintain a contractual agreement with at least one
27 hospital to provide services that are not available at the RHC.^{7,8}

28
29 Unlike FQHCs there are no specific requirements related to the governance, quality improvement,
30 nor culture or language of patients. RHCs do have specific requirements related to their service
31 areas. These centers must serve a community that has been designated as a Primary Care
32 Geographic Health Professional Shortage Area, Primary Care Population-Group Health
33 Professional Shortage Area, MUA, or a governor-designated and secretary-certified shortage area.
34 Additionally, these communities must be designated as non-urbanized. Each year RHCs serve
35 approximately 7 million people throughout 47 states.⁸

36
37 While FQHCs and RHCs are mutually exclusive, they are similar in their basic mission which is to
38 provide health care to individuals who are underserved. There are also similarities in the types of
39 health care providers and types of services permitted. One of the defining differences between the
40 two is the source of funding. FQHCs must receive funding via Section 330 of the PHS Act, while
41 RHC funding comes from alternative federal avenues, such as appropriations from the Centers for
42 Medicare & Medicaid Services. A full comparison outlining the certification requirements for
43 FQHCs and RHCs has been appended to this report.

44 45 PHYSICIAN EXPERIENCE IN FQHCs

46
47 Physicians who work in FQHC settings may experience unique benefits and challenges. While the
48 benefits of working in an FQHC are somewhat difficult to quantify, many physicians report that
49 their work is more gratifying than other settings and that they believe they are helping communities
50 that otherwise would not have adequate access to health care. There are also more tangible benefits

1 to working in an FQHC, such as student loan repayment programs and visas for foreign-born
2 physicians.

3
4 Although these specific benefits and the ability to serve communities that are desperate for quality
5 health care can provide physicians with a sense of fulfillment, there are significant challenges that
6 these physicians face working in FQHCs¹². For example, working in an FQHC does not relieve the
7 physician burden of administrative paperwork. Serving a patient base that has higher rates of public
8 insurance means that physicians are spending more time dealing with the rules, protocols, and
9 paperwork associated with payment. The voluminous amount of paperwork that patients are
10 required to complete to register as an FQHC patient can frequently lead to disruptions in
11 scheduling and physicians spending significant amounts of time reviewing and signing the
12 paperwork. In addition to the increased administrative and regulatory burdens, since physicians at
13 FQHCs are operating in underserved areas it is often difficult to find reasonable timely referrals
14 and coordinate care for patients who may need advanced or specialty care. Some physicians who
15 work in FQHCs report feeling that they are practicing medicine without the support of a medical
16 team or other physicians. For physicians in these settings, providing care to their patients, who are
17 often facing complex medical conditions, can be a significant undertaking. Physicians practicing in
18 FQHCs are frequently part of a limited network of providers in the area they serve, leading to
19 increased stress and working hours in order to attempt to provide quality care on a reasonable
20 timeline to the patients they serve.^{9,10}

21
22 Finally, physicians working in FQHCs often have additional duties related to the supervision of
23 nonphysician providers, which adds another set of tasks to already full schedules. FQHC
24 physicians report spending considerable time on weekends and evenings reviewing cases that are
25 handled by the non-physician practitioners in order to remain in compliance with federal
26 regulations and provide quality care. Notably, physicians working in FQHCs report 11 percent
27 higher burnout than their colleagues working in other practice settings.¹³

28 29 RELEVANT AMA POLICY

30
31 The AMA has a number of existing policies related to rural health and FQHCs. Many of the current
32 AMA policies related to rural health are centered around rural hospitals. Policies H-465.979 and
33 H-465.990 focus on the economic viability of rural hospitals. Each encourages efforts and
34 legislation to support these hospitals' efforts to stay open and serve their communities. Policy
35 D-465.998, established with Council on Medical Service Report 9-J-21, and Policies H-240.971,
36 H-465.978, and H-240.970, all deal with the payment challenges that are faced by many rural
37 physicians and hospitals. The policies both recognize and offer potential solutions for remedying
38 the payment differentials between rural and urban medical care. Finally, Policies H-465.984,
39 H-465.996, and H-465.999 focus on the certification and regulations of rural health care centers
40 and hospitals.

41
42 The Council believes that, in conjunction with FQHCs and RHCs, rural hospitals are another vital
43 strategy to deliver care to rural communities. Notably, the Council's recent 2021 report,
44 "Addressing Payment and Delivery in Rural Hospitals" (Council on Medical Service Report
45 9-J-21) included policy recommendations that remain informative and relevant as to the current
46 state of rural hospitals in America. As previously noted, in order to avoid confusion, this current
47 report has remained focused on health care in non-hospital settings, like FQHCs and RHCs.

48
49 The AMA also has policies related to rural health care that are not centered solely around hospital
50 centered care. Policies H-465.994 and H-465.982 are concentrated around improving the health of
51 rural communities through promoting access to medical care. Policy H-465.978 works to recognize

1 and advocate for fixing the payment bias that is seen between rural and non-rural providers. The
2 policy advocates specifically for payment equity in telehealth legislation. Finally, Policy
3 H-465.980 supports the development and improvement of rural health networks to be centered
4 around the needs of the communities they serve.

5
6 With respect to FQHCs, Policy D-390.923 acknowledges the need for Chronic Care Management
7 payment for physicians who practice in FQHCs. Additionally, the AMA has existing policy
8 surrounding issues of scope of practice for non-physician providers. Specifically, Policies D-
9 35.989, H-160.947, and H-35.965 ensure the regulation of and appropriate scope (including
10 physician supervision) of midwives/CNMs, PAs, NPs, and “related medical personnel.”

11 12 DISCUSSION

13
14 FQHCs are, by definition, located in areas where health care is hard to access. As previously
15 discussed, FQHCs were key in meeting the needs of communities that arose during the peak of the
16 COVID-19 pandemic. FQHCs also have a long history of working to reduce health care disparities
17 and providing preventive and primary care to the underserved.^{8,9} Although the AMA has
18 established policy on improving the health of rural Americans, the Council believes that
19 strengthening our support of FQHCs is warranted.

20
21 One specific method to ensure the viability of FQHCs and RHCs is by reducing physician burnout,
22 one of the core tenets of the AMA’s Recovery Plan for America’s Physicians. Burnout is reported
23 at higher levels in physicians who practice in FQHCs,¹⁰ with significant time and resource burdens
24 related to the administrative aspects of maintaining patient care.^{9,10} The Council believes that this is
25 a potential point of intervention via the addition of AMA policy to ensure that administrative
26 burdens placed on physicians practicing in these settings are not undue and do not influence levels
27 of burnout.

28
29 In addition to ensuring that physicians are able to continue practicing in FQHCs the Council
30 believes that it is also essential that the AMA advocate for continued federal support for these
31 practices. Existing funding for FQHCs should be maintained and increased when feasible to
32 support the expansion of existing clinics and founding of new clinics in underserved communities.
33 The Council understands the importance of FQHCs in providing health care services for
34 communities that have limited access and believes that it is essential to support these clinics and
35 the physicians who practice in them.

36
37 Finally, in order to ensure that patients cared for in FQHCs are receiving high-quality medical care
38 services, it is important to ensure that care is always performed under the supervision of a
39 physician. While regulations for both FQHCs and RHCs allow for practitioners like PAs, NPs, and
40 CNMs to provide care, they do require the supervision of a physician. The AMA does have
41 existing policies that ensure support for state and local medical societies in identifying and
42 advocating for the existing requirement of physician oversight. Each of these additions and
43 reaffirmations of policy will ensure that the AMA works to support essential access points of care
44 for rural communities and the physicians who provide this care.

45 46 RECOMMENDATIONS

47
48 The Council on Medical Service recommends that the following be adopted and that the remainder
49 of the report be filed:

- 1 1. That our American Medical Association (AMA) support certification requirements and
2 other policies that reduce the administrative burden for physicians practicing in Federally
3 Qualified Health Center (FQHCs). (New HOD Policy)
4
- 5 2. That our AMA support sufficient federal funding to maintain the operation and costs
6 associated with establishing and operating a FQHC, FQHC “Look-Alike”, or Outpatient
7 Tribal Facility. (New HOD Policy)
8
- 9 3. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and
10 implement proposals and programs to improve the health of rural communities. (Reaffirm
11 HOD Policy)
12
- 13 4. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of
14 Chronic Care Management reimbursement for all physicians, including those practicing in
15 FQHCs or Rural Health Clinics. (Reaffirm HOD Policy)
16
- 17 5. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the
18 support of state and local medical societies in identifying and working to prevent laws that
19 may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate
20 without the supervision of a physician. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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APPENDIX A: FQHC & RHC REQUIREMENTS

	FEDERALLY QUALIFIED HEALTH CENTERS	RURAL HEALTH CLINIC
SUMMARY	<i>Provide at least primary care services to rural and urban shortage areas.</i>	<i>Provide primary care services for patients who live in rural shortage areas.</i>
SUBTYPES	<ul style="list-style-type: none"> • FQHC (Health Center Program Grantees): Organizations receiving grants under section 330 of the PHS Act. • “Look-Alikes”: Organizations that meet the eligibility requirements of an FQHC, but do not receive funding under section 330 of the PHS Act. • Outpatient Tribal Facilities: Organizations operated by a tribe, tribal organization, or urban Indian Organization. • Examples: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers 	<ul style="list-style-type: none"> • Independent RHC: Clinics that meet the designation for an RHC and are standalone. • Hospital-Based RHC: Clinics that meet the designation for an RHC and are housed at a hospital. • Provider-Based RHC: Clinics that meet the designation for an RHC and are owned and operated by a nursing home or home health agency participating in Medicare.
PRACTITIONERS	Services must be provided by a physician, NP, PA, CNM, CP, CSW, or furnished by the care of an aforementioned provider.	Must have a physician providing medical direction. A NP, PA, or CNM must provide care services at least 50 percent of the time.
FUNDING	Dependent on the subtype of FQHC. For official FQHCs they must receiving funding from grants under section 330 of the PHS Act. FQHC “look-alikes” may receive grants and funding from a variety of sources but <i>cannot</i> receive grants under section 330 of the PHS Act. Outpatient Tribal facilities are funded through the Indian Self-Determination Act or Title V of the Indian Health Care Improvement Act.	Funding is via Medicare reimbursement and patient co-pays.
RECORDS & REPORTING	Must demonstrate an effective procedure for compiling and reporting operations costs, patterns of service use, availability, accessibility, and acceptability of services offered. Must establish and maintain records and provide the authorities with access to examine, copy, and reproduce.	Clinics must file an annual cost report that includes payment rate, reconcile interim payments, graduate medical education adjustments, bad debt shots, and administrative payments.
AUDITING	Must provide an independent annual financial audit and file with the HHS secretary.	Must cooperate with audits done by oversight bodies.
REQUIRED SERVICES	Primary health services including family medicine, internal medicine, pediatrics, OBGYN care, diagnostic lab services, preventative health services, emergency medical services, referrals, case management services, services that enable access to the FQHC, and community education.	Must provide routine diagnostic and lab services, including chemical urine exams, hemoglobin or hematocrit tests, blood sugar tests, and occult blood stool specimen’s exam, pregnancy tests, and primary culturing onsite.
ADDITIONAL SERVICES	Pharmaceutical services, behavioral & mental health services, environmental health services, screening & control of infectious diseases, and injury prevention programs.	May provide care management services like Transitional Care Management (TCM), Chronic Care Management (CCM), General Behavioral Health Integration (BHI), Principal Care Management (PCM), and Psychiatric Collaborative Care Management.
POPULATIONS SERVED	Must serve a MUA or a MUP.	Must serve a non-urbanized community that is designated as a medical shortage area.

QUALITY IMPROVEMENT	Ongoing process that includes clinical services and management.	No specific quality improvement requirements.
PAYMENT & REIMBURSEMENT	Contracted agreement with the State for those eligible for medical assistance through a state plan. Collect appropriate reimbursement from patients who are insured and establish a prepared schedule of fees/payments from patients on a sliding scale, while ensuring no patient is turned away due to a lack of ability to pay. Must encourage patients to participate in insurance programs and plans for which they are eligible.	Reimbursement is paid via a bundled All-Inclusive Rate (AIR) per visit for all qualified primary and preventative care services. Dependent upon services and insurance status, patients may have a copay. For example, those with Part B coverage would pay 20 percent once their deductible is met and the AIR would pay 80 percent.
GOVERNANCE	Governed by a board comprised of a majority (51+ percent) of individuals who receive care at the center. The board must meet at least monthly.	No specific governance requirements.
SERVICE AREA	Must regularly review to ensure that the size of the catchment area is appropriate to ensure that services are available and accessible. Service boundaries should conform with local boundaries to the extent practical and should eliminate barriers to access due to geography.	Must serve a community designated as one of the following: a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, Governor-designated and Secretary-certified shortage area.
COLLABORATIVE AGREEMENTS	Continued efforts to establish and maintain relationships with other health care providers. Must have an ongoing referral relationship with at least one hospital.	Must have arrangements with at least one hospital to provide services that are not available at the clinic.
CULTURAL & LANGUAGE CONSIDERATIONS	If a center serves a community with a “substantial portion” of limited-English speakers, services must be provided in the language and cultural context that is most appropriate. A staff member who is fluent in that language and English must be identified to bridge cultural and linguistic differences.	No specific cultural or language consideration requirements.
VISITS	Each visit must be medically necessary or a qualified preventative health visit. These visits traditionally needed to be face-to-face, but extensions have been made to allow for continued telehealth visits. Should multiple visits be required in the same day, they are considered one cumulative visit. Visits may also take place in the patient’s place of residence should they be home-bound.	Each visit must be medically necessary, a qualified preventive health visit. These visits can take place at the RHC, the patient’s residence, Medicare-covered Part A skilled nursing facility, scene of an accident, or hospice. Visits cannot take place at an inpatient or outpatient hospital department or in a facility specifically excludes RHC visits. Should multiple visits be required in the same day, they are considered one cumulative visit.
EXCLUSIONARY CRITERIA	FQHCs cannot be designated as an RHC.	Cannot be designated as a FQHC, rehabilitation agency, or be a primarily mental disease treatment facility.

Appendix B
AMA Policies Recommended for Reaffirmation

Policy H-465.994, “Improving Rural Health”

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA’s policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
 - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - Advocate for adequate and sustained funding for public health staffing and programs. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22)

Policy D-390.923, “Chronic Care Management Payment for Patients Also on Home Health”

Our AMA will advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics and Federally Qualified Health Centers, for patients in a home health episode. (Res. 801, I-17)

Policy H-160.947, “Physician Assistants and Nurse Practitioners”

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician’s delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22)

Policy H-35.965 “Regulation of Physician Assistants”

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification. (Res. 233, A-17; Modified: Res. 215, I-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-23)

Introduced by: Medical Student Section

Subject: Reconsideration of the Birthday Rule

Referred to: Reference Committee G

1 Whereas, Self-insured coverage is either a self-administered process or a third party
2 administrator where the employer collects premiums from enrollees and assumes
3 responsibility of paying employees' and dependents' medical claims¹; and
4

5 Whereas, The Health Insurance Portability And Accountability Act of 1996 (HIPAA),
6 established protections for "self-insured" and "insured" coverage, whereby newborns,
7 adopted children, and new parents not enrolled under a health plan could enroll under a
8 period of "special enrollment" upon the birth, adoption, or placement for adoption of a new
9 child²; and
10

11 Whereas, Under HIPAA, as long as enrollment occurs within 30 days of birth, health
12 insurance coverage is effective as of the date of birth and cannot be subject to pre-existing
13 condition exclusion²; and
14

15 Whereas, If a health plan's benefits are provided through an insurance company or Health
16 Maintenance Organization (HMO), state laws may amend HIPAA requirements to allow for
17 additional considerations; such as extending the enrollment period²; and
18

19 Whereas, The National Association of Insurance Commissioners (NAIC) is the U.S. standard-
20 setting organization governed by the chief insurance regulators from all 50 states, the District
21 of Columbia, and five U.S. territories to coordinate regulation of multistate insurers³; and
22

23 Whereas, Coordination of Benefits (COB) as defined by the NAIC is the provision to eliminate
24 over-insurance and establish a prompt and orderly claims payment system when a person is
25 covered by more than one group insurance and/or group service plan¹; and
26

27 Whereas, State law permits insurers to follow a COB to determine insurers' responsibilities
28 under an insurance claim in the event the "insured" is covered by more than one health plan,
29 in the identification of a "primary" and "secondary" benefit payer⁴; and
30

31 Whereas, Newborns of parents with separate insurance policies are subjected to a COB at
32 birth^{2,4}; and
33

34 Whereas, The birthday rule is a COB model regulation set by the NAIC in which a newborn
35 takes as primary coverage the plan of the parent whose birthday comes first in the calendar
36 year^{2,4}; and
37

38 Whereas, The recently publicized case of the Kjelshus family resulted in a \$200,000 bill for a
39 NICU stay because the parents were unaware of their coordination of benefits, specifically
40 the birthday rule, that resulted in the father's inferior policy determining their child's insurance

1 coverage solely due to the fact of having a birthday only 2 weeks earlier than his spouse in
2 the calendar year⁵; and

3
4 Whereas, The birthday rule has led to confusion and frustration of parents when a child is
5 automatically enrolled under the parent with the earlier birthday in the calendar year without
6 considering the quality of insurance coverage between both parents, showing that simple
7 awareness is not enough to address the problem⁵; and

8
9 Whereas, H.R.4636I, known as the Empowering Parents' Healthcare Choices Act of 2021,
10 currently in the House Subcommittee on Health, would give parents with dual policies 60
11 days before the birthday rule would take effect from the date of an infant's birth to choose
12 which plan is primary and to notify the insurer of their choice effectively reclaiming parental
13 choice⁶; therefore be it

14
15 RESOLVED, That our American Medical Association support evidence-based legislation that
16 support a parent, or guardian's, choice of their dependent's health insurance plan under the
17 event of multiple insurers (New HOD Policy); and be it further

18
19 RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in
20 Coordination of Benefits" by addition to read as follows:

21
22 **Delay in Payments Due to Disputes in Coordination of**
23 **Benefits, H-190.969**

24 Our AMA:

25 (1) urges state and federal agencies to exercise their authority
26 over health plans to ensure that beneficiaries' claims are promptly
27 paid and that state and federal legislation that guarantees the
28 timely resolution of disputes in coordination of benefits between
29 health plans is actively enforced;

30 (2) includes the "birthday rule" as a last resort only after
31 parents/guardians have been allowed a choice of insurer and
32 have failed to choose, and the "employer first rule" in any and all
33 future AMA model legislation and model medical service
34 agreements that contain coordination of benefits information
35 and/or guidance on timely payment of health insurance claims;
36 (3) urges state medical associations to advocate for the inclusion
37 of the "employer first rule", and "birthday rule" as a last resort only
38 after parents/guardians have been allowed a choice of insurer and
39 have failed to choose, in state insurance statutes as mechanisms
40 for alleviating disputes in coordination of benefits;

41 (4) includes questions on payment timeliness in its Socioeconomic
42 Monitoring System survey to collect information on the extent of
43 the problem at the national level and to track the success of state
44 legislation on payment delays;

45 (5) continues to encourage state medical associations to utilize
46 the prompt payment provisions contained in the AMA Model
47 Managed Care Medical Services Agreement and in AMA model
48 state legislation;

49 (6) through its Advocacy Resource Center, continue to coordinate
50 and implement the timely payment campaign, including the

1 promotion of the payment delay survey instrument, to assess and
2 communicate the scope of payment delays as well as ensure
3 prompt payment of health insurance claims and interest accrual
4 on late payments by all health plans, including those regulated by
5 ERISA; and
6 (7) urges private sector health care accreditation organizations to
7 (a) develop and utilize standards that incorporate summary
8 statistics on claims processing performance, including claim
9 payment timeliness, and (b) require accredited health plans to
10 provide this information to patients, physicians, and other
11 purchasers of health care services. (Modify Current HOD Policy)
12

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

Received: 3/27/23

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RELEVANT AMA POLICY

Delay in Payments Due to Disputes in Coordination of Benefits H-190.969

Our AMA:

- (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
- (2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
- (3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
- (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
- (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;
- (6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and
- (7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness,

and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

Citation: (CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)

Health Insurance for Children H-185.948

Our AMA supports requiring all children to have adequate health insurance as a strategic priority.

Citation: Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18;

Multiple Coverage in Voluntary Health Insurance H-185.999

(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.

Citation: CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98;

Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.

B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.

Citation: CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09;

Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19;

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support

federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Mitigating the Negative Effects of High-Deductible Health Plans H-185.918

Our AMA: (1) encourages ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients; (2) encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year; and (3) encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.

Citation: CMS Rep. 2, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-23)

Introduced by: Medical Student Section

Subject: Providing Reduced Parking for Patients

Referred to: Reference Committee G

- 1 Whereas, In the United States, an estimated four million individuals fail to receive annual
2 medical care due to transportation barriers¹; and
3
- 4 Whereas, Many patients with common illnesses attend multiple outpatient appointments a
5 year, such as one study which showed 47% of patients with hypertension had four or more
6 visits in 2014²; and
7
- 8 Whereas, Parking prices at some of the country's largest medical centers can be as high as
9 \$20 to \$43 per day³⁻⁴; and
10
- 11 Whereas, The public transportation system in the United States varies greatly within the
12 country in terms of usage, location, and infrastructure, with most of the public transport
13 concentrated in the Northeast⁵; and
14
- 15 Whereas, Approximately only a third of patients are within walking distance to their nearest
16 public transportation in certain metropolitan medical centers⁶; and
17
- 18 Whereas, Public transport is not readily available in all locations, such as rural areas where
19 the scarcity of local physicians can still require patients to drive to urban areas for care⁷; and
20
- 21 Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often
22 limited to approved patients within Medicaid and can have many disadvantages, including
23 restrictions on the type and number of rides, the necessity of a social worker to coordinate
24 transportation, having to schedule days in advance, and carpooling with other patients
25 leading to longer travel and wait times⁸; and
26
- 27 Whereas, The average cost of an NEMT in 2014 was \$28, and this price rises in rural and
28 suburban areas that are farther from medical centers^{8,9}; and
29
- 30 Whereas, When surveying older Americans, the group that utilizes the most inpatient and
31 outpatient healthcare, rideshare services were not seen as a practical option, with 74% of
32 patients reporting no knowledge of these services and only 1.7% making use of them¹⁰; and
33
- 34 Whereas, In a study of patients with heart disease, individuals reported the high cost of
35 parking at healthcare facilities as a financial barrier to attending multiple specialist
36 appointments¹¹; and
37
- 38 Whereas, In a study of factors influencing family burden in pediatric hematology/oncology,
39 parking was cited as one of the most disproportionately distressing factors¹²; and

1 Whereas, Nonmedical costs, such as transportation, meals, and child care, have been
2 reported to range from \$50 to \$165 a day, further contributing to a family's financial stress¹³;
3 and
4

5 Whereas, The lower the financial burden a patient has, the less likely they are to miss
6 appointments and adhere to treatment, preventing high cost emergent situations that would
7 lead to hospitals losing money on patients who cannot pay¹⁴; and
8

9 Whereas, Reduced parking fees have been cited as an incentive for patients to travel to
10 hospitals that can offer better treatment than local counterparts¹⁵; and
11

12 Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses,
13 such that providing parking vouchers would only represent a minor loss in revenue while
14 providing a major benefit to patients¹⁶; and
15

16 Whereas, Many hospitals have already implemented programs for patient parking such as
17 reduced monthly rates and free validated parking¹⁷⁻¹⁹; and
18

19 Whereas, Several associations of healthcare facilities focus on developing solutions for and
20 advocating improvements in social and economic aspects of healthcare, including the
21 American Hospital Association, the Federation of American Hospitals, and the Children's
22 Hospital Association²⁰⁻²⁷; and
23

24 Whereas, The American Hospital Association is a national organization of "5,000 hospitals,
25 health care systems, networks, [and] other providers of care" and publishes standards and
26 guidelines on various social and economic aspects of care^{20,21}; and
27

28 Whereas, The Federation of American Hospitals is a national organization of over 1,000
29 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their
30 priorities²²⁻²⁴; and
31

32 Whereas, The Children's Hospital Association is a national organization of over 220 pediatric
33 hospitals and develops and shares solutions with its members on various social and
34 economic aspects of care^{26,27}; therefore be it
35

36 RESOLVED, That our American Medical Association work with relevant stakeholders to
37 recognize parking fees as a barrier to patient care and encourage mechanisms for reducing
38 parking costs for patients and trainees. (New HOD Policy)
39

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

Received: 3/37/23

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Citation: Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18;

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to

emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Citation: Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22;

Voluntary Health Care Cost Containment H-155.998

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

Citation: Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Health Program Electronic Health Record Modernization

Referred to: Reference Committee G

1 Whereas, The Indian Health Service (IHS), an agency within the United States Department of
2 Health and Human Services, provides federal health care services to American Indians and
3 Alaska Natives¹; and
4

5 Whereas, As of 2019, all 122 IHS facilities and more than 300 Tribes and Urban Indian
6 (I/T/U) health facilities use the Resource and Patient Management System (RPMS), which
7 handles everything from patient registration to insurance billing, including the electronic
8 health record (EHR)^{2,3}; and
9

10 Whereas, Although the IHS regularly updates RPMS, it is built on outdated technology from
11 1985 that will become obsolete within the next decade, making new development more
12 difficult each year⁴; and
13

14 Whereas, RPMS exists in a decentralized database system at IHS facilities across the
15 country, making it difficult for patients to share their health information with new providers
16 when they seek care at an outside facility⁴; and
17

18 Whereas, RPMS uses software code and features from the U.S. Department of Veterans
19 Affairs (VA) "VistA" EHR system⁴; and
20

21 Whereas, In 2017, the VA made the decision to fully transition away from VistA to a
22 commercial EHR by 2028 due to limited interoperability with other EHR products, known
23 cybersecurity vulnerabilities, and costly maintenance⁴; and
24

25 Whereas, The IHS will stop receiving VA VistA updates making it more challenging and
26 costly to update RPMS⁴; and
27

28 Whereas, In 2019, the U.S. Government Accountability Office listed RPMS as a critical
29 federal legacy system in need of modernization, because its underlying code will be
30 unsupported in the next 5 to 10 years⁵; and
31

32 Whereas, In 2019, the IHS did not have a Congressional appropriation or proposed budget
33 for health information technology (HIT) and electronic health record modernization⁵; and
34

35 Whereas, The VA serves 9 million patients per year and the IHS serves 2.2 million patients
36 per year^{6,7}; and
37

38 Whereas, In fiscal year (FY) 2020, the VA received \$1.5 billion to modernize their EHR, while
39 the IHS only received an appropriation of \$8 million to modernize their EHR⁸⁻⁹; and

1 Whereas, In FY21, the VA and IHS received an appropriation of \$2.6 billion and \$34.5 million
2 to continue EHR modernization efforts, respectively, demonstrating a significant gap in
3 federal health care expenditures per capita¹⁰⁻¹¹; and
4

5 Whereas, In 2021, after a period of Tribal consultations, the IHS announced the IHS Health
6 Information Technology Modernization Program, through which they would fully replace
7 RPMS at IHS facilities with commercially available solutions, with no estimated completion
8 date due to funding challenges¹²; and
9

10 Whereas, Many Tribes and Urban Indian health facilities compact and contract with the IHS
11 to assume full funding and control over all programs, services, and functions, and activities
12 provided by the IHS¹³; and
13

14 Whereas, Non-IHS Tribal health facilities (79.4% of all I/T/U facilities) do not all use RPMS,
15 minimizing their involvement in and potential benefit from any programs managed by and
16 funds provided to the IHS for EHR modernization¹⁴; and
17

18 Whereas, A 2019 study of 21 Tribes in the Pacific Northwest found that over half used non-
19 RPMS EHR and medical claims systems, and EHR modernization costs up to \$500,000 per
20 Tribe with monthly maintenance costs up to \$3,000 per Tribe³; and
21

22 Whereas, The IHS National Tribal Budget Formulation Workgroup, representing all 12 IHS
23 Service Areas, made FY23 funding recommendations for EHR modernization efforts ranging
24 from \$282 million to \$1.76 billion¹⁶; therefore be it
25

26 RESOLVED, That our American Medical Association support adequate funding for electronic
27 health record modernization and maintenance costs for Tribal and Urban Indian Health
28 Programs with active self-governance compacts and contracts with the Indian Health Service.
29 (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation:(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate

construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).

2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.

3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

Citation: BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians ability to provide high quality patient care;

2. Support team-based care;

3. Promote care coordination;

4. Offer product modularity and configurability;

5. Reduce cognitive workload;

6. Promote data liquidity;

7. Facilitate digital and mobile patient engagement; and

8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;

2. Advocate to federal and state policymakers to develop effective HIT policy;

3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;

4. Partner with researchers to advance our understanding of HIT usability;

5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and

6. Promote the elimination of Information Blocking.

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

Citation: BOT Rep. 19, A-18; Reaffirmation: A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-23)

Introduced by: Medical Student Section

Subject: Interrupted Patient Sleep

Referred to: Reference Committee G

- 1 Whereas, Sleep is critical for brain function and systemic physiology¹; and
2
3 Whereas, The most at-risk patients for poor sleep are categorized as acutely ill and
4 hospitalized²; and
5
6 Whereas, The American Academy of Sleep Medicine notes that hospital and long-term care
7 environments can negatively impact patients' sleep due to nursing care activities such as
8 frequent nocturnal vital signs and tests, and recommends greater focus on sleep health in
9 these populations^{3-6,16}; and
10
11 Whereas, Hospitalized patients experience disrupted and poor quality sleep with frequent
12 arousals, poor nocturnal sleep efficiency, an increase in stage 2 sleep, a reduction or
13 absence of deep or slow wave sleep, and a reduction or absence of rapid eye movement
14 (REM) sleep⁷; and
15
16 Whereas, Hospital noise is a common complaint amongst patients which results in impaired
17 sleep and is associated with adverse outcomes¹⁶; and
18
19 Whereas, Positive correlations were shown between the number of interruptions at night and
20 mean number of as-needed pain medications given, systolic blood pressure, and heart rate
21 at various times⁸; and
22
23 Whereas, Sleep disruption can lead to the development of delirium, hypertension,
24 dyslipidemia, cardiovascular disease, metabolic syndrome, type 2 diabetes mellitus,
25 colorectal cancer, lower physical functioning after release from the hospital, higher overall
26 mortality 1-year post discharge, delayed healing, and fatigue, which may hinder patients'
27 participation in recovery activities^{1,2,9,10}; and
28
29 Whereas, Among medical inpatients, shorter sleep duration and worse sleep efficiency were
30 associated with greater odds of hyperglycemia, which increases the risk of myocardial
31 infarction, stroke, likelihood of admission to the intensive care unit, longer lengths of stay,
32 decreased likelihood to be discharged home compared to patients with known diabetes and
33 those without hyperglycemia¹¹; and
34
35 Whereas, Interventions decreasing circadian disruptions resulted in shorter length of stay,
36 lower readmission rates, and improved self-reported emotional and mental health for
37 patients¹²; and
38
39 Whereas, Sleep intervention bundles which included reduced alarm volume, closing bedroom
40 doors at night, earplugs, eye masks, and light dimming in ICU units are associated with better

1 sleep, a reduced incidence, duration and risk of developing delirium, and, in 2021, a project
2 aimed at reducing delirium through sleep promotion in 2 inpatient units found that delirium
3 decreased by 33% and 45%, respectively, on the units over 1 year¹³⁻¹⁵; and

4
5 Whereas, Sleep improvement projects increased the percentage of patients who self-
6 reported five or more hours of uninterrupted sleep, improved patients' care and sleep
7 experience, and included fewer room entries, fewer minutes of in-room activity, decreased
8 sound during rest time, and empowered patients to ask their providers to minimize nighttime
9 disruptions^{16,17,19,20}; and

10
11 Whereas, Interventions to minimize sleep disturbances lead to fewer symptoms and
12 significantly lower sleep disturbance scores in antepartum patients, decreased as-needed
13 sedative use by 49%, and led to an increase in sleep-friendly orders, sleep promoting venous
14 thromboembolism prophylaxis, and a decrease in night time disruptions^{18,21,22}; and

15
16 Whereas, Decreasing nighttime vital sign measurement has been shown to increase patient
17 satisfaction²³; and

18
19 Whereas, A trial that utilized a risk stratification tool to classify patients into high or low risk
20 categories to eliminate overnight vital sign monitoring for low risk patients reported no
21 significant adverse events for low-risk patients²⁴; and

22
23 Whereas, Our American Medical Association identifies adolescent insufficient sleep and
24 sleepiness as a public health issue (H-60.930) and supports diagnosis and management of
25 sleep and sleep disorders (H-295.894); and

26
27 Whereas, Our AMA does not have policy that evaluates or supports current inpatient sleep
28 guidelines to improve patient sleep; therefore be it

29
30 RESOLVED, That our American Medical Association encourage physicians, trainees,
31 inpatient care teams, and hospital administration to reduce the number of patient sleep
32 interruptions as much as possible, including considering the impact of circadian and
33 environmental factors on sleep, to only those interruptions which are necessary and cannot
34 be performed at another time (New HOD Policy); and be it further

35
36 RESOLVED, That our AMA support efforts to improve quality, duration, and timing of
37 inpatient sleep. (New HOD Policy)

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

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RELEVANT AMA POLICY

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Citation: Res. 503, A-10; Appended: CSAPH Rep. 06, A-16;

Medical Education on Sleep and Sleep Disorders H-295.894

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education.

Citation: Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18;

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932

Our AMA:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22;

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
 - b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
 - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
- b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
- c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
- f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
- g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
- i) Scheduled time providing patient care services of limited or no educational value should be minimized.
- j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
- k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
- l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
- m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
- o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-23)

Introduced by: Senior Physicians Section
Subject: Aging and Dementia Friendly Health Systems
Referred to: Reference Committee G

- 1 Whereas, The *AMA Principles of Medical Ethics* encourages participation in activities to improve
2 community and public health as well as access to medical care for all people”¹; and
3
4 Whereas, Dementia and related diagnoses affect inexorably growing numbers of American
5 seniors; and
6
7 Whereas, Immediately addressing long-term care services and support systems for seniors
8 would allow for adjustments to best accommodate future demographic shifts; and
9
10 Whereas, Documentation on relative costs of home care versus facility-based nursing care for
11 patients with dementia indicates that home care is more cost effective²; and
12
13 Whereas, AMA policies address health care in the home as well as cost-effectiveness/cost-
14 benefit of assisted in-home versus nursing home care for Alzheimer’s disease and related
15 disorders; and
16
17 Whereas, The John A. Hartford Foundation and the Institute for Healthcare Improvement have
18 released comprehensive evidence-based guidance for healthcare professionals entitled: *Age-
19 Friendly Health Systems: A Guide to Using the 4Ms While Caring for Older Adults*, which
20 highlights, “What Matters,” “Medications,” “Mentation,” and “Mobility,”³; and
21
22 Whereas, Cost-effective, equitable, and quality health care for all may be achieved by
23 comprehensive education, community grants for long-term home-care services, and appropriate
24 support systems for seniors; and
25
26 Whereas, Development of dementia friendly communities may permit patients and families living
27 with dementia to improve health outcomes; therefore be it
28
29 RESOLVED, That our American Medical Association lobby Congress, state legislatures and
30 appropriate organizations to expand community and home-based services to promote and
31 support “aging in place” (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA develop educational resources for all health care professionals
34 about ways that successful outcomes have been achieved to appropriately support patients as
35 they age including those with dementia both in their homes as well as in health care systems.
36 (Directive to Take Action)

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

Received: 4/26/23

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RELEVANT AMA POLICY

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;

(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

Citation: Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17;

Alzheimer's Disease H-25.991

Our AMA:

(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;

(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;

(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;

(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;

(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;

(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and

(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-23)

Introduced by: Medical Student Section

Subject: Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis

Referred to: Reference Committee G

- 1 Whereas, A 2018 study from the Centers for Disease Control and Prevention (CDC)
2 estimated the prevalence of autism spectrum disorder (ASD) among adults aged 8 years to
3 be 1 in 44¹; and
4
- 5 Whereas, Applied Behavioral Analysis (ABA) is currently the most widely available and
6 commonly used state-funded form of autism therapy in Canada and the United States^{2,3}; and
7
- 8 Whereas, Autism treatment represents a fragmented industry that consists of a mixture of for-
9 profit and nonprofit organizations, with the top nine for-profit chains estimated to have a
10 combined revenue of \$547 million and a market value close to \$2 billion with future growth
11 expected⁴; and
12
- 13 Whereas, An ABA software company reports over 3 billion in claims processed annually for
14 about 1,300 practices highlighting the prevalence of ABA use as an intervention for
15 individuals with autism⁵; and
16
- 17 Whereas, Autism Speaks lists 3,194 centers across the United States who offer ABA therapy
18 as of 2022⁶; and
19
- 20 Whereas, ABA was conceived in 1961 by Dr. Ole Ivar Lovaas to condition neurotypical
21 behaviors in children he viewed as “incomplete humans”⁷⁻¹⁰; and
22
- 23 Whereas, Desired behavior is often defined by the adult or behaviorist without input or
24 requirement of consent from the child and may include non-harmful stimming or coping
25 behaviors^{2,3,8,11,12}; and
26
- 27 Whereas, ABA uses behavior modification techniques to eliminate behaviors deemed
28 undesirable^{2,8,11-14}; and
29
- 30 Whereas, ABA practices are historically based in abuse such as holding autistic children's
31 communication hostage through the use of their devices as leverage, and denying basic
32 rights such as food and toileting privileges^{2,3,8,11,14-18}; and
33
- 34 Whereas, Modern ABA still abides by the founding principle of making a child appear
35 “normal” or “indistinguishable from one’s peers”, which serves to separate the humanity of
36 the individual with autism from desired behaviors^{2,8,15}; and
37
- 38 Whereas, A 2018 study found that Adults with autism who have received ABA are more
39 prone to suicide¹⁹; and

1 Whereas, ABA has been repeatedly linked to Post Traumatic Stress Disorder (PTSD), with
2 46% of 460 ABA participants meeting the diagnostic threshold for PTSD in an online
3 survey²⁰; and
4

5 Whereas, Adults with autism have been continuously outspoken about the trauma incurred
6 by ABA practices experienced in their childhood^{2,14,16-18}; and
7

8 Whereas, A 2012 literature review found the evidence base for services for adults with an
9 ASD to be underdeveloped²¹; and
10

11 Whereas, A 2018 Cochrane review recommend further research after reporting very weak
12 evidence in support of ABA²²; and
13

14 Whereas, A 2022 informal online community survey found that 71% of adults with autism
15 responded “disagree” or “strongly disagree” to the statement “Generally speaking, I support
16 ABA therapy for autistic children”²³; and
17

18 Whereas, A 2020 Department of Defense report demonstrated a lack of correlation between
19 improvement in symptoms and hours of direct ABA services, found that the improvements
20 recorded were due to reasons other than ABA services, and ABA services did not meet the
21 TRICARE hierarchy of evidence standard for medical and proven care²⁴; and
22

23 Whereas, A 2021 study on conflicts of interest (COIs) in autism early intervention research
24 found COIs to be prevalent and under-reported, with 70% of studies containing a conflict of
25 interest and less than 6% declaring them as such²⁵; and
26

27 Whereas, Current research supports alternatives to ABA such as the Developmental,
28 Individual Differences, and Relationship-based (DIRTM) program, the PLAY Project,
29 individualized Early Social Interaction (ESI) and, Social Communication, Emotional
30 Regulation, and Transactional Support (SCERTSTM)^{24,26-29}; and
31

32 Whereas, Current AMA policy supports the use of ABA through its advocacy of coverage of
33 ABA and the evidence-based treatment for autism and fails to recognize its harms or
34 controversial nature within the community at large; therefore be it
35

36 RESOLVED, That our American Medical Association support research towards the
37 evaluation and the development of interventions and programs for autistic individuals (New
38 HOD Policy); and be it further
39

40 RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive
41 spectrum of primary and specialty care that recognizes the diversity and personhood of
42 individuals who are neurodivergent, including people with autism (Directive to Take Action);
43 and be it further
44

45 RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied
46 Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and
47 deletion as follows:

1 **Standardizing Coverage of Applied Behavioural Analysts**
2 **Therapy for Persons with Autism Spectrum Disorder, H-**
3 **185.921**
4 Our AMA supports coverage and reimbursement for evidence-
5 based ~~treatment of services for~~ Autism Spectrum Disorder
6 including, but not limited to, ~~Applied Behavior Analysis Therapy.~~
7 (Modify Current HOD Policy)

Fiscal Note: Not yet determined.

Received: 4/3/23

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RELEVANT AMA POLICY

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

Community-Based Treatment Centers H-160.963

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.

Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-23)

Introduced by: American Academy of Physical Medicine & Rehabilitation
American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Expediting Repairs for Power and Manual Wheelchairs

Referred to: Reference Committee G

- 1 Whereas, Patients with neuromusculoskeletal weakness or other disabilities, such as
2 amputations, paralysis, cerebral palsy, stroke, traumatic brain injury, multiple sclerosis,
3 muscular dystrophy, arthritis, and spinal cord injury, who are unable to walk must use wheeled
4 mobility devices in their homes and in their communities; and
5
- 6 Whereas, Power and manual wheelchairs are medically necessary specialized equipment used
7 by individuals with mobility disabilities and designed to help individuals perform activities of daily
8 living (ADLs) to the fullest extent possible; and
9
- 10 Whereas, The process of qualifying for power and manual wheelchairs is well established and
11 requires physician certification of medical necessity, and for more complex wheelchairs,
12 requires a comprehensive evaluation of long-term need for the device; and
13
- 14 Whereas, The Medicare program and many other payors will not replace a power or manual
15 wheelchair unless it is more than five years old; and
16
- 17 Whereas, Medicare and most other payors currently do not cover preventative maintenance of
18 power and manual wheelchairs; and
19
- 20 Whereas, There are more than five million wheelchair users in the United States and of those
21 users, many will require some type of wheelchair repair during the five-year useful life of the
22 mobility device^{1,2}; and
23
- 24 Whereas, Prompt action is needed when the patient's power or manual wheelchair is in need of
25 repairs in order to operate safely, return to work or school, enable the patient to get out of bed,
26 move about the home, perform activities of daily living, or participate in community activities;
27 and
28
- 29 Whereas, Prolonged bedrest or inactivity due to lack of a safely operating power or manual
30 wheelchair can result in multiple medical complications for the patient including, but not limited
31 to, pressure sores, pneumonia, increased weakness, depression; and
32
- 33 Whereas, The wheelchair repair process is currently flawed and causes delays in repairs due to
34 multiple factors including payors' requirements for unnecessary documentation, such as prior
35 authorization and new prescriptions, inadequate reimbursement policies to compensate
36 suppliers for the costs of repairs, such as uncompensated labor and costs of travel to the
37 patient's home to repair the wheelchair and the replacement or repair parts, and delays in
38 availability of replacement or repair parts due to supply chain issues; and

1 Whereas, Most payors, except Medicare and the Veterans Administration, do not pay for a
2 substitute rental wheelchair while the patient's own wheelchair is being repaired; therefore be it
3

4 RESOLVED, That our American Medical Association encourage all payors to improve the
5 process of and reduce barriers to patients obtaining wheelchair repairs for patient-owned power
6 and manual wheelchairs, to ensure that repairs and services are safe, affordable, and timely,
7 and support mobility and independence for those who utilize power and manual wheelchairs
8 (New HOD Policy); and be it further
9

10 RESOLVED, That our AMA encourage all payors to eliminate unnecessary paperwork including
11 requiring prior authorization for basic repairs and proof of continuous need for patient-owned
12 power and manual wheelchairs (New HOD Policy); and be it further
13

14 RESOLVED, That our AMA encourage all payors to add coverage and payment for
15

- 16 (1) temporary rental of a substitute wheelchair when repairs require the primary
17 wheelchair to be taken out of the home;
- 18 (2) preventive maintenance; and
- 19 (3) travel to and from the patient's home when the patient cannot transport the
20 wheelchair to a repair facility (New HOD Policy); and be it further
21

22 RESOLVED, That our AMA encourage all suppliers of power and manual wheelchairs to service
23 wheelchairs they supply to patients and to permit consumers to perform simple self-repairs and
24 have access to necessary parts. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-23)

Introduced by: American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy

Subject: UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal
Endoscopy Procedures

Referred to: Reference Committee G

1 Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all
2 diagnostic and surveillance colonoscopies, esophagogastroduodenoscopies (EGDs), and
3 capsule endoscopies; and
4

5 Whereas, This policy is contradictory to UHC's announced plans to eliminate 20% of its current
6 prior authorizations starting the summer of 2023 and introduce a "Gold Card" program in 2024;
7 and
8

9 Whereas, The American Medical Association 2021 Prior Authorization Physician Survey
10 revealed that¹;

- 11 • 93% of physicians report care delays as a result of your authorization.
- 12 • 82% of physicians report prior authorization can lead to treatment abandonment.
- 13 • 34% of physicians reported prior authorization has led to a serious adverse event.
- 14 • 51% of physicians report prior authorization has interfered with a patient's ability to
15 perform their job responsibilities; and
16

17 Whereas, The AMA 2021 Prior Authorization Physician Survey also reveals that physicians
18 complete an average of 45 prior authorizations a week¹; and
19

20 Whereas, The AMA's current position is that prior authorization, if used at all, must be used
21 judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and
22 other providers² and discourages volume reduction solutions such as the elimination of prior
23 authorization requirements for regularly approved care, gold-carding programs, and other
24 exemption programs³; and
25

26 Whereas, The Office of Inspector General (OIG) review of Medicare Advantage Organizations
27 (MAOs) appealed preauthorization and payment denials, MAOs overturned 75 percent of their
28 own denials. The OIG also found that beneficiaries and providers appealed only 1 percent of
29 denials to the first level of appeal⁶; and
30

31 Whereas, A 2022 American College of Gastroenterology survey found that more than 50% of
32 members surveyed reported that prior authorization led to a serious adverse event in patients⁴
33 and a 2022 American Gastroenterological Association survey found that 56% of members
34 reported that prior authorization restrictions have "significantly" impacted patient access to
35 clinically appropriate treatments and patient clinical outcomes¹⁸; and

1 Whereas, It also revealed that the alternative treatments were less effective, more costly to
2 patients, less tolerable and/or supported by a lower level of clinical evidence⁴; and
3

4 Whereas, 2022 AMA data reveal 46% of respondents reported that prior authorization policies
5 led to urgent or emergency care for patients and 86% reported prior authorization led to higher
6 utilization of healthcare resources⁵; and
7

8 Whereas, All of the procedures flagged for prior authorization by UHC have robust multi-society
9 clinical guidelines and quality indicators that can be used with a directed utilization review
10 policy^{7,8,9,10,11,12,13,14,15}; and
11

12 Whereas, This UHC policy is a blanket obstruction to the practice of diagnostic and therapeutic
13 endoscopy rather than a directed utilization review of suspected outliers. AMA Prior
14 Authorization and Utilization Principle #19 states “Health plans should restrict utilization
15 management programs to “outlier” providers whose prescribing or ordering patterns differ
16 significantly from their peers after adjusting for patient mix and other relevant factors”¹⁶; and
17

18 Whereas, The AMA, AHA, AHIP, BCBS, MGMA and the APhA have agreed to a Consensus
19 Statement on Improving the Prior Authorization Process including an agreement to “Encourage
20 the use of programs that selectively implement prior authorization requirements based on
21 stratification of health care providers’ performance and adherence to evidence-based
22 medicine”⁷; and
23

24 Whereas, UHC has failed to provide, and denied access to, any documentation showing recent
25 evidence of overutilization or to identify specific CPT procedure codes of concern in spite of
26 multiple requests; and
27

28 Whereas, A coalition of over 90 patient advocacy groups, national and state medical
29 associations urged UHC not to move forward with these prior authorization rules, due to the
30 significant impact on access to care and to the patient-physician relationship; therefore be it
31

32 RESOLVED, That our American Medical Association strongly advocate with all state and federal
33 agencies for the cancellation of UHC’s 2023 blanket prior authorization policy directed at
34 endoscopic procedures in favor of a directed utilization review of presumed outliers (Directive to
35 Take Action); and be it further
36

37 RESOLVED, That our AMA redouble its efforts to promote state laws such as the AMA’s
38 example “Ensuring Transparency in Prior Authorization Act” (Directive to Take Action); and be it
39 further
40

41 RESOLVED, That our AMA communicate with the various state insurance commissioners
42 concerning UHC’s prior authorization policy change, which has the potential to adversely affect
43 access, quality, and equity of G.I. patient care. (Directive to Take Action)

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

Received: 5/2/23

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16. Prior Authorization and Utilization Management Reform Principles <https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf>
17. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>
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RELEVANT AMA POLICY

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical

necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20; Reaffirmation: A-22;

Payer Accountability H-320.982

Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.

(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17; Reaffirmation: A-22;

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior

Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22;

Fair Reimbursement for Administrative Burdens D-320.978

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22;

Promoting Accountability in Prior Authorization D-285.960

Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21;

Managed Care H-285.998

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee

financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at

the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22;

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22;

Require Payers to Share Prior Authorization Cost Burden D-320.980

Our AMA will petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.

Citation: Res. 811, I-19; Reaffirmation: A-22;

Administrative Simplification in the Physician Practice D-190.974

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-23)

Introduced by: Medical Student Section

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: Reference Committee G

- 1 Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have
2 undergone a previous cesarean section undergo trial of vaginal birth; and
3
4 Whereas, Many hospitals ban the practice of TOLAC¹⁻³; and
5
6 Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections
7 because women eligible for vaginal birth are not given the opportunity for TOLAC⁴; and
8
9 Whereas, Women may have to travel far distances to find a hospital or provider that is willing to
10 let them attempt TOLAC⁵; and
11
12 Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all
13 United States births in 2017⁶⁻⁸; and
14
15 Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not
16 associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm
17 delivery for future pregnancies⁹; and
18
19 Whereas, Vaginal births result in decreased rates of respiratory distress and other complications
20 for newborns as compared to cesarean section births^{10,11}; and
21
22 Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than
23 elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%¹²; and
24
25 Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection
26 between women undergoing TOLAC versus ERCD¹²; and
27
28 Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000
29 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for
30 women with no contraindications¹³; and
31
32 Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at
33 hospitals that provide at least basic maternal care^{14,15}; and
34
35 Whereas, TOLAC is a viable alternative to cesarean section that should be considered during
36 the antepartum course of care and be part of the physician-patient decision process¹⁶; and
37
38 Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment
39 allows patient control and autonomy over their healthcare decisions; and

1 Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from
2 respecting patient choice; and

3
4 Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients^{3,17};
5 and

6
7 Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making
8 between patient and physician in order to help patients make informed decisions about their
9 health care; therefore be it

10
11 RESOLVED, That our American Medical Association support the elimination of broad hospital-
12 based restrictions that prevent physicians from offering a trial of labor after cesarean to their
13 patients when medically appropriate (New HOD Policy); and be it further

14
15 RESOLVED, That our AMA encourage hospitals to establish clear and transparent policies on
16 trial of labor after cesarean in order to improve the process of patient-physician shared decision-
17 making. (New HOD Policy)

Fiscal Note: Not yet determined.

Received: 5/1/23

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RELEVANT AMA POLICY

E-1.1.1 Patient-Physician Relationships

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

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

Issued: 2016

E-1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.

(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment.

Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.

(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.

(d) To make decisions about the care the physician recommends and to have those decisions respected.

A patient who has decision-making capacity may accept or refuse any recommended medical intervention.

(e) To have the physician and other staff respect the patient's privacy and confidentiality.

(f) To obtain copies or summaries of their medical records.

(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

Issued: 2016

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.

Citation: Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Shared Decision-Making H-373.997

Our AMA:

1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.

Citation: CMS Rep. 7, A-10; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 06, A-19;

Informational Reports

BOT Report(s)

- 03 2022 Grants and Donations
- 05 Update on Corporate Relationships
- 06 Redefining AMA's Position on ACA and Healthcare Reform
- 07 AMA Performance, Activities, and Status in 2022
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023
- 10 American Medical Association Health Equity Annual Report
- 16 Informal Inter-Member Mentoring
- 19 Medical Community Voting in Federal and State Elections

CEJA Opinion(s)

- 01 Amendment to Opinion 4.2.7, "Abortion"
- 02 Amendment to Opinion E-10.8, "Collaborative Care"
- 03 Pandemic Ethics and the Duty of Care

CEJA Report(s)

- 06 Use of De-identified Patient Information D-315.969
- 07 Use of Social Media for Product Promotion and Compensation
- 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

CLRPD Report(s)

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership
- 02 A Primer on the Medical Supply Chain

CMS Report(s)

- 06 Health Care Marketplace Plan Selection

REPORT OF THE BOARD TRUSTEES

B of T Report 03-A-23

Subject: 2022 Grants and Donations

Presented by: Sandra Adamson Fryhofer, MD, Chair

- 1 This informational financial report details all grants or donations received by the American
- 2 Medical Association during 2022.

**American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2022
Amounts in thousands**

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	\$ 202
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	314
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	477
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	897
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	246
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	549
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	24
Government Funding		<u>2,709</u>
American Academy of Dermatology	2022 Annual Meeting of House of Delegates - Presidential Inauguration	15
American Association for the Advancement of Science	International Congress on Peer Review and Scientific Publication	3
American College of Physicians	International Congress on Peer Review and Scientific Publication	10
American Medical Association Foundation (via contribution from Daiichi Sankyo)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	9
American Medical Association Foundation (via contribution from Genentech)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	45
American Medical Association Foundation (via contribution from Pfizer Inc.)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	23
Massachusetts Medical Society	International Congress on Peer Review and Scientific Publication	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	3
Nonprofit Contributors		<u>128</u>
Cabell Publishing Company	International Congress on Peer Review and Scientific Publication	10
Elsevier	International Congress on Peer Review and Scientific Publication	10
John Wiley & Sons, Inc.	International Congress on Peer Review and Scientific Publication	30
MPS Limited (formerly Highwire Press)	International Congress on Peer Review and Scientific Publication	10
Silverchair Science + Communications, Inc.	International Congress on Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress on Peer Review and Scientific Publication	30
Other Contributors		<u>100</u>
Total Grants and Donations		<u>\$ 2,937</u>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-23

Subject: Update on Corporate Relationships

Presented by: Sandra Adamson Fryhofer, MD

1 PURPOSE

2

3 The purpose of this informational report is to update the House of Delegates (HOD) on the results
4 of the Corporate Review process from January 1 through December 31, 2022. Corporate activities
5 that associate the American Medical Association (AMA) name or logo with a company, non-
6 Federation association or foundation, or include commercial support, currently undergo review and
7 recommendations by the Corporate Review Team (CRT) (Appendix A).

8

9 BACKGROUND

10

11 At the 2002 Annual Meeting, the HOD approved revised principles to govern the American
12 Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on
13 Corporate Relationships." These guidelines for American Medical Association corporate
14 relationships were incorporated into the corporate review process, are reviewed regularly, and were
15 reaffirmed at the 2012 and 2022 Annual Meeting. AMA managers are responsible for reviewing
16 AMA projects to ensure they fit within these guidelines.

17

18 YEAR 2022 RESULTS

19

20 In 2022, 92 activities were considered and approved through the Corporate Review process. Of the
21 92 projects recommended for approval, 48 were conferences or events, 11 were educational content
22 or grants, 27 were collaborations or affiliations, five were member programs, and one was an
23 American Medical Association Foundation (AMAF) program. See Appendix B for details.

24

25 CONCLUSION

26

27 The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk
28 assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW

RECOMMENDATIONS FOR 2022

<u>PROJECT NO.</u>	<u>PROJECT DESCRIPTION</u>	<u>CORPORATIONS</u>	<u>APPROVAL DATE</u>
CONFERENCES/EVENTS			
18477	IAIME Annual Event 2022 - Exhibit – Sponsorship with AMA name and logo.	International Academy of Independent Medical Evaluators Veritas Association Management Axis Administration Services Independent Medical Transcription, Inc ABCDisability, Inc	01/11/2022
18380	WBL Annual Summit 2022 and 2023 - Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation AMGEN Anthem, Inc McKesson Tivity Health Epstein Becker Green MEDecision AMN Healthcare Aveus, LLC Johnson & Johnson West Monroe Common Spirit Newport Healthcare Progeny Health United Health Group AArete Consulting Healthcare Leadership Council Hello Heart MCG Health Mintz NTT Data Tabula Rasa Healthcare Trustmark VillageMD	01/13/2022
18538	NHMA Virtual COVID-19 Briefing – Sponsorship of virtual event with AMA name and logo.	National Hispanic Medical Association George Mason University	01/14/2022

		George Washington University Howard University Elizabeth Dole Foundation	
18470	March of Dimes Gala - Repeat sponsorship with AMA name and logo.	March of Dimes Samsung General Motors NACDS Foundation Proctor and Gamble Pampers Aflac American Beverage Association Volkswagen BNSF Railway Rocket Mortgage	01/19/2022
18460	ViVE 2022 Conference - Sponsorship with AMA name and logo.	ViVE College of Healthcare Information Management Executives HLTH	01/26/2022
18698	National Press Club Event featuring Dr. Harmon – Sponsorship with AMA name and logo.	National Press Club	02/03/2022
18691	HIMSS Annual Conference – Repeat sponsorship with AMA and CPT name and logo.	Health Information and Management Systems Society Premier, Inc Seal Shield Athenahealth Symplr ZS Consulting Guidehouse Vyaire Coding Services Group Masimo Red Hat	02/09/2022
18980	Third Horizon Strategies International Women’s Day Forum – Sponsorship with AMA name and logo.	Third Horizon Strategies MATTER Chicago Alight Solutions	03/02/2022
18987	NHIT Summit – Sponsorship with AMA name and logo.	National Health IT Collaborative for the Underserved Sanitas Medical Center hims&hers DocuSign Health Innovation Alliance	03/04/2022

18968	NHMA Conference – Sponsorship with AMA name and logo.	National Hispanic Medical Association Centene Corporation Abbott Laboratories Davita Pfizer Johnson & Johnson Genentech Eli Lilly and Company Vertex PhRMA Sanofi Traverse NovoNordisk Orasure Technologies, Inc. Orlando Health Med Group Planned Parenthood Action Fund Sentara Healthcare Penn State Health	03/11/2022
19058	National Rx Drug Abuse and Heroin Summit – Repeat sponsorship with AMA name and logo.	HMP Global Psychiatry and Behavioral Health Learning Network Operation Unite University of Kentucky Northern Kentucky University Bamboo Health Deterra RTI International Advantage EMS World Georgia Department of Behavioral and Development Disabilities NASA DAD – National Association of State Alcohol and Drug Abuse Directors SAM – Smart Approaches to Marijuana PROUD – Peers in Recovery from Opioid Use and Dependence PTACC – Police, Treatment and Community Collaborative R2ISE Recovery	03/21/2022
19112	AAPC HEALTHCON 2022 – US and International – Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders AHA Coding Clinic HC Pro Charter Oak State College Foresee Medical	03/23/2022

		GHR RevCycle Workforce MidOcean Partners MediCodio OS2 Healthcare Solutions Unify Healthcare Services	
19202	Credentialing State Shows – Repeat sponsorship with AMA name and logo.	Illinois Association of Medical Staff Services Texas Society for Medical Services Specialists Florida Association of Medical Staff Services California Association of Medical Services Specialists MD Staff ABMS Solutions Hardenbergh Group MD Review AMN Healthcare/Silversheet VerityStream PreCheck NAMSS PASS Edge-U-Cate SkillSurvey	04/01/2022
19263	AMA 20th Annual Research Challenge – AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank	04/13/2022
19267	AMA Release the Pressure (RTP) and AKA Derby Day Scholarship Brunch – Sponsorship of AKA -hosted event.	AKA Sorority Eta Omega Chapter Weight Watchers Ad Council Ebony iHeartRadio Hortense B. Perry Foundation Weight Watchers Fashion Fair Tgin Auda.B Henry Schein	04/14/2022
19259	ATA Conference and Expo – Repeat sponsorship with AMA name and logo.	American Telemedicine Association AliveCor BioIntelliSense Pexip Health Northeast Telehealth Resource Center Optum eDevice	04/15/2022

		ATA Action	
19247	AHCJ Conference – Sponsorship with AMA name and logo.	Association of Healthcare Journalists Nixon Peabody InterSystems HCA Healthcare Meadows Mental Health Policy Institute St. David’s Foundation Arnold Ventures Robert Wood Johnson Foundation Leona and Harry Helmsley Trust Gordon and Betty Moore Foundation The Commonwealth Fund Episcopal Health Foundation The Kresge Foundation Pcori The Pew Charitable Trust John A. Hartford Foundation Mayo Clinic NYS Health Foundation Health Foundation for Western and Central New York California Health Care Foundation The Colorado Health Foundation Milbank Memorial Fund Missouri Foundation for Health Rhode Island Foundation Burroughs Wellcome Fund	04/19/2022
19428	Rush University Medical Center – West Side Walk for Wellness – Repeat sponsorship with AMA name and logo.	Rush Health Blue Cross and Blue Shield of Illinois	05/02/2022
19250	Social Innovation Summit – Presenting sponsorship with AMA and AMAF names and logos.	Landmark Ventures	05/10/2022
19647	NLGJA Annual Convention – Repeat sponsorship with AMA name and logo.	National Lesbian and Gay Journalists Association The Association of LGBTQ Journalists	05/23/2022
19649	Modern Healthcare’s Annual Virtual Briefing – Repeat sponsorship with AMA name and logo.	Crain Communications Modern Healthcare Digital Magazine	06/01/2022

19699	Black Men in White Coats Summit – Repeat sponsorship with AMA name and logo.	Black Men in White Coats American Association of Colleges of Osteopathic Medicine Health & Medicine Policy Research Group Chicago Area Health Education Center	06/02/2022
19647	NABJ/NAHJ Annual Convention – Repeat sponsorship with AMA name and logo.	National Association of Black Journalists National Association of Hispanic Journalists	06/03/2022
19743	Becker’s Collaborations - Repeat sponsorship of CEO and CFO Roundtable, Annual Meeting, and webinar collaboration with Becker’s with AMA name and logo.	Becker’s Hospital Review ASC Communications LLC	06/07/2022
19648	MVJ Annual Convention – Repeat sponsorship with AMA name and logo.	Military Veterans in Journalism CNN The Washington Post Fox News NBC U.S. Veterans Magazine DAV (Disabled American Veterans) The Lenfest Institute John S. Knight Program Facebook With Honor Action Wyncote Foundation Knight Foundation Wall Street Journal Google News Initiative	06/30/2022
19848	NAMSS – Annual Virtual Conference - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties CIMRO Quality Healthcare Solutions DecisionHealth MD-Staff Medallion National Commission on Certification of Physician Assistants PBI Education	06/30/2022

		PreCheck QGenda RLDatix Silversheet Symplr The Greeley Company The Hardenbergh Group UC San Diego PACE Program VerityStream	
19919	SNOMED CT Virtual Expo 2022 – Repeat sponsorship of virtual event with AMA name and logo.	Systemized Nomenclature of Medicine (SNOMED) West Coast Informatics Meridian DLT Unai Software Consultants ERMLEX The Phoenix Partnership PHAST (France) VIDAL Group Conteir.no (Norway)	07/07/2022
19970	Genetic Health Information Network Summit 2022 – Repeat sponsorship of virtual event with AMA name and logo.	Genetic Health Information Network Concert Genetics Illumina Genome Medical	07/12/2022
20075	NMA Annual Convention and Scientific Assembly – Sponsorship with AMA name and logo.	National Medical Association Council on Concerns of Women Physicians (CCWP) American College of Rheumatology The Lupus Initiative	07/19/2022
20209	IAIABC Forum 2022 – Repeat sponsorship with AMA name and logo.	Industrial Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthesystems ODG by MCG Health Enlyte SFM Mutual Insurance Ebix Insurance Software Verisk	08/10/2022

		HealthTech, Inc Rising Medical Solutions	
20246	SAWCA All Committee Conference – Repeat sponsorship with AMA name and logo.	Southern Association of Workers’ Compensation Administrators Verisk National Council on Compensation Insurance Safety National Optum	08/16/2022
19989	Northwestern University Third Coast Augmented Intelligence (AI) Health Bowl – Student competition sponsorship with AMA name and logo.	3rd Coast AI for Health Bowl Vizient Health Highmark Health Leap of Faith Technologies	08/19/2022
20375	CFHA Annual Integrated Care Conference – Sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Cambia Health Solutions Elevance Health Merakey Mid-American Mental Health Technology Transfer Center Mayo Clinic - National Center for Integrated Behavioral Health Comagine Health Health Federation of Philadelphia National Register of Health Service Psychologists	08/30/2022
20400	TeleHealth Academy 2022 – Repeat sponsorship with AMA name and logo.	Nashville Entrepreneur Center eVISIT NTT DATA Best Buy Health Akin Gump LLP LBMC Accounting TeleHealth Solutions Sage Growth Partners North Highland	08/31/2022
20411	Nourishing Hope -Fighting Hunger Feeding Hope Annual Event – Repeat sponsorship with AMA name and logo.	The Feinberg Foundation Northwestern School of Medicine Allstate Donald R. Wilson Jr (DRW) Venture Capital Kovitz Wealth Management Huntington Bank Purposeful Wealth Advisors Barack Ferrazzano LLP Saul Ewing, Arnstein and Lehr	09/01/2022

20431	ATA Telehealth Awareness Week – Repeat co-hosted webinar with AMA name and logo.	The American Telemedicine Association	09/02/2022
20388	West Side United Media Event – Event to announce sponsorship with AMA name and logo.	West Side United City Club of Chicago The Hatchery Allies for Community Business Rush Hospital Lurie Children’s Hospital Northern Trust Lawndale Christian Development Corporation	09/08/2022
20465	GCC eHealth Workforce Development Conference 2022 – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council UAE Cyber Security Council American Health Information Management Association (AHIMA) Infermedica Orion Health Philips Corporation Malaffi	09/08/2022
20507	NMF Gratitude Gala – Sponsorship with AMA name and logo.	National Medical Fellowships Cedars – Sinai Hospital Dana-Farber Cancer Institute Public Service Electric and Gas CO Association of American Medical Colleges (AAMC) Merck Don Levin Trust Mayo Clinic	09/12/2022
20630	HLTH 2022 Innovation Sponsorship Program – Sponsorship with AMA name and logo.	HLTH LLC	09/28/2022
20703	29th Annual Princeton Conference – Repeat sponsorship with AMA name and logo.	AARP Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation	09/30/2022

		MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	
20735	Alliance for Health Policy Dinner – Repeat sponsorship with AMA name and logo.	Blue Cross Blue Shield Association Elevance Health Kaiser Permanente Otsuka Pharmaceutical Premier Health Welsh, Carson, Anderson, and Stowe	10/03/2022
20699	Greater Chicago - Leadership Series – Sponsorship of leadership development series with AMA name and logo.	Leadership Greater Chicago Northern Trust Health Care Service Corporation First Midwest Bank Price Waterhouse Cooper William Blair JP Morgan Chase & Company FHLBank Chicago Slalom Blue Cross Blue Shield of Illinois ComED AON BMO Harris Bank Allstate MacArthur Foundation Nicor Gas	10/06/2022
20783	IHI Forum 2022 – Sponsorship with AMA name and logo.	Institute for Healthcare Improvement Ethicon Digital Solutions Johnson & Johnson Exact Science Corporation GOJO Industries Gordon and Betty Moore Foundation Healthgrades Michigan Hospital Association Minitab Statistical Software Novartis Premier Healthcare Alliance Riskconnect, Inc Software John A. Hartford Foundation Vizient	10/27/2022

21140	“The Color of Care” Screening – Co-host screening with AMA name and logo at HLTH conference.	HLTH LLC Cityblock Health Health Tech 4 Medicaid	11/01/2022
21350	Managing the EHR Inbox Conference – Sponsorship with AMA name and logo.	University of California - San Francisco The Doctor’s Company The Women’s College Hospital at University of Toronto	11/21/2022
21400	Primary Care Collaborative: “Better Health: Block by Block” Conference – Sponsorship with AMA name and logo.	University of Pittsburgh Medical Center (UPMC) Blue Shield of California American Psychological Association American Academy of Physician Assistants (AAPA) Elevance Health Johnson & Johnson Blue Cross Blue Shield Michigan GTMRx (Get the Medications Right) Institute American Association of Retired Persons (AARP) CVS	11/23/2022
21693	The ROCS Foundation’s Health Summit at Sundance – Sponsorship with AMA name and logo.	The Jewish Healthcare Foundation Pittsburgh Regional Health Initiative (PRHI) Health Careers Futures (HCF) Women's Health Activist Movement Global (WHAM Global) The John A. Hartford Foundation Center for Health Incentives and Behavioral Economics (CHIBE) - Penn Medicine	12/13/2022

EDUCATIONAL CONTENT OR GRANT

18088	Becker's Whitepaper – AMA co-branding and sponsorship of white paper.	Becker's Hospital Review	01/20/2022
18667	Clinical Problem Solvers – Educational Series – AMA EdHub hosted podcasts with AMA name and logo.	The Clinical Problem Solvers	02/07/2022
18767	Return on Health Report – Repeat project for co-branded white paper on findings for behavioral health integration.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/10/2022
18850	Mary Ann Liebert Journal Articles – AMA EdHub co-branded collaboration on women's healthcare.	Mary Ann Liebert Inc	02/28/2022
17629	Abu Dhabi Department of Health – AMA and CPT logos featured in customer case study.	Department of Health – Abu Dhabi Malaffi Health - Information Exchange Muashir	03/11/2022
19206	Edge-U-Cate Credentialing School Sponsorship – Repeat sponsorship with AMA name and logo.	Edge-U-Cate ABMS Solutions Certi-Facts American Osteopathic Information Association Symplr Morisey Associates	04/06/2022
19464	"The Value of Telehealth Amongst Specific Clinical Use Cases" – Co-branded white paper with AMA name and logo.	Laurel Health Advisors LLC	05/05/2022
19643	Medical News Literacy Project – Literacy content for K-12 students with AMA name and logo.	News Literacy Project Checkology	05/25/2022

19950	ScholarRx Proof of Concept (POC) Project – Co-branded AMA content for ScholarRx platform.	ScholarRx	07/15/2022
20245	Future of Health Research – Co-branded white paper on value of virtual healthcare.	Manatt Health - Manatt, Phelps & Phillips, LLP	08/23/2022
21505	Opioid Overdose Epidemic Project – Research on best practice policies to help end overdose epidemic, with AMA name and logo.	Manatt Health - Manatt, Phelps & Phillips, LLP	11/15/2022

**Collaborations/
Affiliations**

18945	Advancing Equity through Quality and Safety Peer Network – Collaboration to advance equity in healthcare organizations with AMA name and logo.	The Joint Commission Brigham and Women’s Hospital Atlantic Health System University of Iowa Hospitals MD Anderson Cancer Center Ochsner Health The Children’s Hospital of Philadelphia Vanderbilt University Medical Center Dana-Farber Cancer Institute University of Wisconsin Hospitals and Clinics	03/01/2022
18482	Telehealth Access for America Campaign – AMA name and logo use for campaign on permanent approval of Medicare coverage for telehealth.	Telehealth Access for America American Hospital Association AARP American Heart Association American Telemedicine Association Adventist Health Policy Association Consumer Technology Association Athena Health, Executives for Health Innovation Teladoc Health Alliance for Connected Care Partnership to Advance Virtual Care Ascension Johns Hopkins Medicine Included Health	01/12/2022
18132	Providers Clinical Support System Collaboration – Co-branded materials for healthcare providers on treating Opioid Use Disorder (OUD).	Minnesota Medical Association Providers Clinical Support System	01/17/2022
18552	DirectTrust Membership Program - Membership with AMA name and logo.	DirectTrust Information Exchange for Human Services (IX4HS) Consensus Body	01/18/2022
19912	MAP Dashboards for HCOs – Repeat AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	LifeCare Value Network LifeCare Oklahoma LifeCare Ascension	07/06/2022

18857	All In Campaign – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA Foundation American Association of Colleges of Nursing American College of Emergency Physicians American Hospital Association American Nurse Foundation Collaborative for Health and Renewal in Medicine Johnson & Johnson Center for Health Worker Innovation Medicine Forward National Black Nurses Association Philippines Nurses Association of America Schwartz Center for Compassionate Care The Physicians Foundation	02/22/2022
18934	Collaborative for Health and Renewal in Medicine (CHARM) - Charter committed to reducing healthcare worker burnout with AMA name and logo.	Arnold P. Gold Foundation Associate Ophthalmologists Atlantic Medical Group Cleveland Clinic Florida Edward-Elmhurst Healthcare Gillette Children’s Specialty Healthcare Hartford Healthcare Huntington Hospital Lehigh Valley Health Network Mountain Area Health Education Center Moffitt Cancer Center Nemours Children’s Health System NYU Langone Hospital Penn Medical Lancaster General Health Saint Francis Hospital Tulane University School of Medicine University of Florida College of Medicine University of Washington School of Medicine VITAL Worklife	03/01/2022

20181	AMA Grand Rounds – Webinar series on health equity supported by collaborators/sponsors with AMA name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice Education American Society of Addiction Medicine Sinai Chicago Boston Medical Center HealthBegins Accreditation Council for Continuing Medical Education Rush University Medical Center RespectAbility American Board of Internal Medicine Foundation The Hastings Center Council of Medical Specialty Societies	08/08/2022
19225	Rise to Health Coalition – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	Institute for Healthcare Improvement (IHI) Race Forward Groundwater Institute PolicyLink HealthBegins American Health Insurance Plans (AHIP) Council of Medical Specialty Societies (CMSS) National Association of Community Health Centers (NACHC)	04/14/2022
19102	Axual Credentialing – Credentialing platform partnership with AMA name and logo.	Axual	03/28/2022
19195	Prime Health – Additional collaborator for “In Full Health” equitable innovation project.	Prime Health	03/30/2022
19214	Rock Health – Repeat annual sponsorship with AMA name and logo.	Rock Health Fenwick and West Law Firm Amazon Web Services (AWS) Morgan Stanley Goldman Sachs Myovant Russell Reynolds	04/08/2022

19698	<p>“The Color of Care” Documentary Medical Advisory Board – Participation on advisory board with AMA name and logo.</p>	<p>Dr. Ala Stanford Center for Health Equity Black Doctors COVID-19 Consortium</p>	06/07/2022
19964	<p>Joy in Medicine – Repeat AMA recognition program for outstanding healthcare organizations.</p>	<p>Atlantic Health System Baylor Scott & White – The Heart Hospital Boston Children's Pediatric Physicians' Organization Centura Health Edward-Elmhurst Health Gillette Children's Specialty Healthcare Hartford HealthCare Moffitt Cancer Center MultiCare Health System Nemours Children's Health Samaritan Health Services Sea Mar Community Health Centers The Christ Hospital Health Network The Permanente Medical Group Cleveland Clinic Oak Street Health Cooper University Health Care Johns Hopkins Medicine Medical College of Wisconsin, Froedtert Children's Hospital Northwell Health Physician Partners Penn Medicine Lancaster General Health Temple University Health System Tulane University School of Medicine UMass Memorial Health UCI Health University of Mississippi Medical Center University of New Mexico School of Medicine UW Medicine Valley Medical Center</p>	07/07/2022
19917	<p>New MAP BP program channel partners - with AMA name and logo.</p>	<p>Relevant Healthcare, Inc. Azara Healthcare i2i Population Health</p>	07/11/2022

19931	AMA/Ad Council Flu Vaccine Campaign – Co-branded public awareness campaign.	Ad Council	07/11/2022
19695	Frontline Physician and Nurses Documentary Series – Documentary series with AMA name and logo.	Afropunk National Medical Association	07/13/2022
20054	Health IT End User Alliance – Collaboration focusing healthcare IT principles on patient and care team needs with AMA name and logo.	American Health Information Management Association American Academy of Family Physicians American College of Physicians American College of Surgeons American Medical Group Association Federation of American Hospitals Medical Group Management Association Oregon Community Health Information Network Premier, Inc. Sutter Health Wisconsin Hospital Association	07/20/2022
20506	National Health IT Collaborative (NHIT) for the Underserved – Sponsorship with AMA name and logo.	Gordon and Betty Moore Foundation Multicultural Media Telecom and Internet Council Wiley Law Mass General Brigham Puerto Rican Primary Care Association Network Association of Clinics for the Underserved AmeriHealth Visionary Consulting Partners Acacia Network National Association of Community Health Centers MITRE Corporation Infor Software NextGen Alliance Chicago Tyler Technologies Health Choice Network CCI Center for Civic Innovations Visualutions Keralty Tracfone Wireless	09/14/2022

		Summit Health Institute for Research and Education CIMIT Point of Care Technology in Primary Care RCHN Community Health Foundation	
20571	Alternative Payment Models (APMs) White Paper – Tri-branded white paper to advance the adoption of APMs with AMA name and logo.	America’s Health Insurance Plans National Association of Accountable Care Organizations Manatt Health HMA-Leavitt Aurrera Health Bailit Health	09/20/2022
20652	DTA Webinar - AMA-hosted CPT webinar.	Digital Therapeutics Alliance	09/22/2022
20687	National Academy of Medicine (NAM) Well-Being Collaborative – Sponsorship with AMA name and logo.	Alliance of Independent Academic Medical Centers ChristianaCare CRICO LCMC Health National Quality Forum RENEW Patient Advocate Foundation UAB Medicine UnitedHealth Group	09/29/2022
20788	Alternative Payment Models (APMs) Coalition – Advocacy and Awareness program to advance the adoption of APMs with AMA name and logo.	National Association of Accountable Care Organizations Healthcare Transformation Task Force Premier, Inc.	10/11/2022
20976	Chicago Area Public Affairs Group – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group	11/10/2022
21427	National Academy of Medicine (NAM) Action Collaborative – Sponsorship of stakeholder meeting series.	Joint Commission American Association of Critical- Care Nurses Johns Hopkins Medical College of Wisconsin UnitedHealth Group Cedars-Sinai American Dental Education Association	11/28/2022

21458	SAWCA – Repeat sponsorship with AMA name and logo.	Southern Association of Workers Compensation Administrators National Council on Compensation Insurance Optum Sedgwick	11/30/2022
21660	The Gravity Project – AMA co-hosted CPT webinar with name and logo.	HL7 Fast Healthcare Interoperability Resources HL7 Fast Healthcare Interoperability Resources Foundation US Core Data for Interoperability (USCDI) Logical Observation Identifiers Names and Codes (LOINC) International Classification of Diseases (ICD – 10) SNOMED CT National Library of Medicine	12/05/2022

MEMBER PROGRAMS

18311	Laurel Road Perks Program – Laurel Road Affinity Program with AMA name and logo.	Laurel Road Bank Brooklinen Sakara P.volve Getaway Kidpass The White Coat Investor Task Rabbit Lyft	01/27/2022
20380	UWorld – Medical Student Outreach Program (MSOP) test prep incentive partner with AMA name and logo.	UWorld	08/29/2022
20736	GradFin Affinity Program – Laurel Road Bank subsidiary added to AMA member benefit program with AMA name and logo.	Laurel Road Bank GradFin	10/17/2022
20729	Mercedes-Benz Affinity Program - Automobile member benefit program with AMA name and logo.	Mercedes Benz	10/14/2022
	AMA Insurance Agency Medical Malpractice Insurance Program – Co-branded medical malpractice insurance program with AMAIA name and logo.	Indigo Concert Group	12/02/2022

AMA FOUNDATION

AMA Foundation Corporate Donors
– AMAF name and logo association
with 2022 corporate donors.

Amgen
Bristol Myers Squibb
Eli Lilly
Genentech
GlaxoSmithKline
Grail
Henry Schein
Merck
Novartis
Pfizer
PhRMA
Sanofi

08/29/2022

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-23

Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy
2 D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which calls on our
3 American Medical Association (AMA) to “develop a policy statement clearly outlining this
4 organization’s policies” on several specific issues related to the Affordable Care Act (ACA) as well
5 as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy
6 also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report
7 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original
8 intent of the policy. This report serves as an update on the issues and related developments
9 occurring since the most recent meeting of the HOD.

10

11 IMPROVING THE AFFORDABLE CARE ACT

12

13 Our AMA continues to engage policymakers and advocate for meaningful, affordable health care
14 for all Americans to improve the health of our nation. Our AMA remains committed to the goal of
15 universal coverage, which includes protecting coverage for the 20 million Americans who acquired
16 it through the ACA. Our AMA has been working to fix the current system by advancing solutions
17 that make coverage more affordable and expanding the system’s reach to Americans who fall
18 within its gaps. Our AMA also remains committed to improving health care access so that patients
19 receive timely, high-quality care, preventive services, medications, and other necessary treatments.

20

21 Our AMA continues to advocate for policies that would allow patients and physicians to be able to
22 choose from a range of public and private coverage options with the goal of providing coverage to
23 all Americans. Specifically, our AMA has been working with Congress, the Administration, and
24 states to advance our plan to cover the uninsured and improve affordability as included in the
25 “2022 and Beyond: AMA’s Plan to Cover the Uninsured.” The COVID-19 pandemic initially led
26 to many people losing their employer-based health insurance. This only increased the need for
27 significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate
28 has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included
29 in the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.

30

31 We also continue to examine the pros and cons of a broad array of approaches to achieve universal
32 coverage as the policy debate evolves.

33

34 Our AMA has been advocating for the following policy provisions:

35

36 Cover Uninsured Eligible for ACA’s Premium Tax Credits

37

- 38 • Our AMA advocates for increasing the generosity of premium tax credits to improve premium
39 affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible
40 individuals and families with incomes between 100 and 400 percent federal poverty level

1 (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable
2 and advanceable premium tax credits to purchase coverage on health insurance exchanges.

- 3 • Our AMA has been advocating for enhanced premium tax credits for young adults. In order to
4 improve insurance take-up rates among young adults and help balance the individual health
5 insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium
6 tax credits could be provided with “enhanced” premium tax credits—such as an additional \$50
7 per month—while maintaining the current premium tax credit structure that is inversely related
8 to income, as well as the current 3:1 age rating ratio.
- 9 • Our AMA is also advocating for an expansion of the eligibility for and increasing the size of
10 cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250
11 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for
12 cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-
13 pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-
14 sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions,
15 would lessen the cost-sharing burdens many individuals face, which impact their ability to
16 access and afford the care they need.

17 18 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

19
20 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for
21 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population
22 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- 23
24 • Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and
25 enrollment, including auto enrollment.
- 26 • Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA
27 believes that Medicaid work requirements would negatively affect access to care and lead to
28 significant negative consequences for individuals’ health and well-being.

29 30 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

31
32 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible
33 for financial assistance under the ACA, either due to their income, or because they have an offer of
34 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by
35 ACA’s premium tax credits, this population can continue to face unaffordable premiums and
36 remain uninsured.

- 37
38 • Our AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for
39 premium tax credits beyond 400 percent FPL.
- 40 • Our AMA has been advocating for the establishment of a permanent federal reinsurance
41 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance
42 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher
43 premiums across the board in anticipation of higher-risk people enrolling in coverage. Section
44 1332 waivers have also been approved to provide funding for state reinsurance programs.
- 45 • Our AMA also is advocating for lowering the threshold that determines whether an employee’s
46 premium contribution is “affordable,” allowing more employees to become eligible for
47 premium tax credits to purchase marketplace coverage.
- 48 • Our AMA strongly advocated for the Internal Revenue Service (IRS) proposed regulation on
49 April 7, 2022 that would fix the so-called “family glitch” under the ACA, whereby families of
50 workers remain ineligible for subsidized ACA marketplace coverage even though they face

1 unaffordable premiums for health insurance coverage offered through employers. The
2 proposed regulation would fix the family glitch by extending eligibility for ACA financial
3 assistance to only the family members of workers who are not offered affordable job-based
4 family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

5
6 EXPAND MEDICAID TO COVER MORE PEOPLE

7
8 Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found
9 themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because
10 they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals
11 do not have a pathway to affordable coverage.

- 12
13 • Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

14
15 New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist
16 more than two million nonelderly uninsured individuals who fall into the “coverage gap” in states
17 that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below
18 the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy
19 maintains that coverage should be extended to these individuals at little or no cost, and further
20 specifies that states that have already expanded Medicaid coverage should receive additional
21 incentives to maintain that status going forward.

22
23 AMERICAN RESCUE PLAN OF 2021

24
25 On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021.
26 This legislation included the following ACA-related provisions that will:

- 27
28 • Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance
29 Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s Medicaid
30 expansion and covers the new enrollment period per requirements of the ACA.
31 • Invest nearly \$35 billion in premium subsidy increases for those who buy coverage on the
32 ACA marketplace.
33 • Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose
34 income is above 400 percent of the FPL for 2021 and 2022.
35 • Give an option for states to provide 12-month postpartum coverage under State Medicaid and
36 CHIP.

37
38 ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA,
39 eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between
40 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and
41 advanceable premium credits that are inversely related to income to purchase coverage on health
42 insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the
43 Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a
44 result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual
45 and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for
46 premium tax credit assistance. Individuals eligible for premium tax credits include individuals who
47 are offered an employer plan that does not have an actuarial value of at least 60 percent or if the
48 employee share of the premium exceeds 9.83 percent of income in 2021.

1 Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for
2 two years, lowering the cap on the percentage of income individuals are required to pay for
3 premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost
4 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
5 their income. Notably, resulting from the changes, eligible individuals and families with incomes
6 between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion
7 states) now qualify for zero-premium silver plans, effective until the end of 2022.

8
9 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133
10 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they
11 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and
12 other cost-sharing amounts.

13 14 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

15
16 On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through
17 the highly partisan budget reconciliation process, which allows both the House and Senate to pass
18 the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to
19 bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of
20 budgetary requirements. The Inflation Reduction Act included provisions that extended for three
21 years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

22
23 The Inflation Reduction Act did not include provisions to close the Medicaid “coverage gap” in the
24 states that have not chosen to expand.

25 26 ACA ENROLLMENT

27
28 According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans
29 have signed up for or were automatically re-enrolled in the 2023 individual market health insurance
30 coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period
31 (OEP) on November 1, 2022, through January 15, 2023.

32 33 *TEXAS VS. AZAR* SUPREME COURT CASE

34
35 The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the
36 third time, granting the petitions for certiorari from Democratic Attorneys General and the House
37 of Representatives. Oral arguments were presented on November 10, 2020, and a decision was
38 expected before June 2021. The AMA filed an amicus brief in support of the Act and the
39 petitioners in this case.

40
41 On February 10, 2021, the U.S. Department of Justice under the new Biden Administration
42 submitted a letter to the Supreme Court arguing that the ACA’s individual mandate remains valid,
43 and, even if the court determines it is not, the rest of the law can remain intact.

44
45 This action reversed the Trump Administration’s brief it filed with the Court asking the justices to
46 overturn the ACA in its entirety. The Trump Administration had clarified that the Court could
47 choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal
48 experts pointed out, the entire ACA would be struck down if the Court rules that the law is
49 inseparable from the individual mandate—meaning that there would be no provisions left to
50 selectively enforce.

1 On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the
2 individuals challenging the law have a legal standing to sue. The Court did not touch on the larger
3 issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress
4 eliminated the penalty for failing to obtain health insurance.

5
6 With its legal status now affirmed by three Supreme Court decisions, and provisions such as
7 coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health
8 care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

9
10 *BRAIDWOOD MANAGEMENT VS. BECCERRA* FEDERAL COURT CASE

11
12 A case before a federal district court judge in the Northern District of Texas, *Braidwood v. Becerra*
13 (formerly *Kelley v. Becerra*), would eliminate the ACA requirement that most health insurance
14 plans cover preventive services without copayments. Those filing the case object to paying for
15 coverage that they do not want or need, particularly for those items or services that violate their
16 religious beliefs, such as contraception or PrEP drugs. If the case is ultimately successful, health
17 plan enrollees will also lose access to full coverage for dozens of preventive health services,
18 including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart
19 disease, and other diseases and medical conditions.

20
21 The AMA and 61 national physician specialty organizations issued a joint statement on July 25,
22 2022, sounding the alarm about the millions of privately insured patients who would be affected by
23 an adverse ruling.

24
25 On September 7, 2022, Texas federal court judge Reed O'Connor ruled that part of the ACA's
26 requirement that health plans cover preventive services without copayments was unconstitutional.
27 He further held that that one of the plaintiffs, Braidwood Management, a for-profit company, could
28 not be required to cover PrEP through its employer health plan because of Braidwood's religious
29 objections. Judge O'Connor did not immediately issue an order blocking enforcement of the
30 coverage requirements. He also did not specify whether such an order would be nationwide, for his
31 district only, for all the named plaintiffs, or only for Braidwood. These issues were held for further
32 argument before Judge O'Connor.

33
34 On November 30, 2022, the Litigation Center of the American Medical Association and State
35 Medical Societies, along with the American College of Obstetricians and Gynecologists, American
36 Academy of Pediatrics, American Academy of Family Physicians, and four other national
37 associations filed an amicus brief warning against the court ordering broad, nationwide relief,
38 arguing that such a decision would imperil access to vital preventive care that keeps patients
39 healthier and lowers overall costs for the health care system.

40
41 On March 30, 2023, after supplemental briefing from the parties and *amici*, the federal district
42 court issued its opinion and order addressing the remedies and final judgment. Most notably, the
43 court ordered that all actions taken by HHS to implement or enforce the preventive care coverage
44 requirements in response to an "A" or "B" recommendation by the U.S. Preventive Services Task
45 Force on or after March 23, 2010 are vacated and enjoined going forward. The court also ordered
46 that the named plaintiffs need not comply with the PrEP mandate, based on the court's prior ruling
47 that the PrEP mandate violates the plaintiffs' rights under the Religious Freedom Restoration Act.
48 On March 31, the federal government filed its notice of appeal, and the litigation will continue.

49

1 In a statement following the ruling, AMA President Jack Resneck, Jr., M.D., expressed alarm at the
2 ruling and urged employers and insurers to maintain this first dollar coverage while legislative and
3 judicial next steps are considered.

4
5 SGR REPEAL

6
7 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing
8 the SGR was signed into law by President Obama on April 16, 2015.

9
10 The AMA is now working on unrelated new Medicare payment reduction threats and is currently
11 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

12 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

13
14 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,
15 included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to
16 replace the IPAB.

17
18 CONCLUSION

19
20 Our American Medical Association will remain engaged in efforts to improve the health care
21 system through policies outlined in Policy D-165. 938 and other directives of the House of
22 Delegates. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD
23 meeting have been accomplished, our primary goal now related to health care reform is
24 stabilization of the broken Medicare physician payment system, including the need for inflation-
25 based positive annual updates and reform of budget neutrality rules.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-23

Subject: AMA Performance, Activities, and Status in 2022

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 Policy G-605.050, “Annual Reporting Responsibilities of the AMA Board of Trustees,” calls for
2 the Board of Trustees to submit a report at the American Medical Association (AMA) Annual
3 Meeting each year summarizing AMA performance, activities, and status for the prior year.

4

5 INTRODUCTION

6

7 The AMA’s mission is to promote the art and science of medicine and the betterment of public
8 health. As the physician organization whose reach and depth extend across all physicians, as well
9 as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results
10 and initiatives that enable physicians to improve the health of the nation.

11

12 *Representing physicians with a unified voice*

13

14 In a year that marked the organization’s 175th anniversary, the AMA launched the Recovery Plan
15 for America’s Physicians, a five-point strategy to support and strengthen our nation’s physician
16 workforce. The plan was introduced at the Annual Meeting of the AMA House of Delegates in
17 June 2022. The five objectives of the plan focus on prior authorization, Medicare payment reform,
18 scope of practice creep, physician burnout and telehealth.

19

20 The AMA has been leading a multiyear effort to bring about Medicare payment models that give
21 physicians greater flexibility in care delivery, minimize administrative burdens that detract from
22 patient care, and improve the financial viability of physician practices. In 2022, we led a robust
23 advocacy campaign that was joined by more than 150 organizations representing more than 1
24 million physicians that minimized the 8.5% Medicare physician payment cuts slated for 2023. In
25 addition, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the
26 pay-as-you-go sequester tied to the American Rescue Plan Act

27

28 The AMA scored more than 40 state-level victories by working in partnership with state medical
29 associations and national medical specialty societies. Pressing the fight for patient safety, we
30 stopped bills that would have expanded the scope of practice for nurse practitioners and other
31 APRNs, helped defeat legislation nationwide that would have allowed physician assistants to
32 practice independently without physician oversight, and turned away measures allowing
33 pharmacists to prescribe medications and optometrists to perform surgery.

34

35 The AMA continues to aggressively urge the Department of Veterans Affairs to reject the
36 inappropriate scope of practice expansions outlined in the Federal Supremacy Project while
37 advocating as strongly as ever in favor of physician-led teams and against improper scope
38 expansions in all 50 states and the District of Columbia.

39

40 In cases ranging from COVID-19 standards of care and firearm regulations to climate change and
41 transgender rights, the AMA continued to fight for physicians and patients in state and federal

1 courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership*
2 *Council v. HHS*, which forced the federal government to take the first steps toward banning
3 menthol cigarettes. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's*
4 *Health Organization* decision, the AMA joined numerous briefs outlining the need for access to
5 reproductive care and opposing third-party interference in the patient-physician relationship.

6
7 The AMA elevated the voice of physician leadership on critical issues of public health, securing
8 more than 175 billion media impressions representing nearly \$1.6 billion in estimated ad value and
9 achieving a commanding 43 percent share of voice among healthcare entities in the media.

10
11 *Removing obstacles that interfere with patient care*

12
13 The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization
14 burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by
15 the U.S. House of Representatives in September. Its provisions were developed from the consensus
16 statement on prior authorization reform that the AMA helped draft.

17
18 The AMA represented the interests of physicians in a federal regulatory task force exploring
19 methods to streamline the prior authorization process. The AMA also played a key role in the
20 successful adoption of prior authorization reform laws in Georgia, Iowa and Michigan, and paved
21 the way for reform efforts in 2023 in nearly a dozen more states.

22
23 The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports
24 in 2022 relating to physician burnout and improving professional satisfaction and practice
25 sustainability. The AMA helped secure the enactment of the Dr. Lorna Breen Health Care Provider
26 Protection Act, which enables a broad range of essential physician wellness resources, including
27 evidence-based programs dedicated to improving mental health and resiliency.

28
29 The AMA STEPS Forward® Program exceeded 1.6 million lifetime users with new training
30 programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and
31 four videos.

32
33 The AMA expanded its work in promoting physician wellness through its Joy in Medicine™
34 Health System Recognition Program, honoring nearly 30 health care organizations that represented
35 more than 80,000 physicians.

36
37 The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral
38 Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical
39 assistance to physician practices seeking to deliver integrated care to patients. This effort builds on
40 the success of the Overcoming Obstacles series with several new webinars on topics such as
41 assembling a behavioral health integration care team and addressing physician and patient mental
42 health.

43
44 *Driving the future of medicine*

45
46 The AMA played a key role in securing passage of legislation to extend Medicare telehealth
47 flexibilities through the end of 2024. We launched model legislation that states can use to advance
48 telehealth coverage and policies. The AMA further supported telehealth expansion by expanding
49 our already-impressive library of print and online resources promoting evidence-based telehealth
50 services to now include strategies to advance health equity in virtual care. The launch of the
51 AMA's Telehealth Immersion Program supports practices in the implementation and optimization

1 of telehealth. The program expanded in 2022 with seven webinars, five clinical case studies, two
2 virtual panel discussions and one mini bootcamp.

3
4 The industry-leading AMA Ed Hub™ online education portal received 6 million views and
5 continued to expand its programs, affiliations and reach to support live broadcasts and enhance
6 multimedia capabilities. The number of external education providers grew by 10 to encompass 35
7 organizations with the addition of the American Board of Pediatrics and the American Academy of
8 Allergy, Asthma and Immunology, among others.

9
10 The AMA, led by its Center for Health Equity, strengthened its physician engagement with the
11 launch of seven new social justice education modules published on the AMA Ed Hub™ learning
12 platform. These modules focus on strategies to advance equity through quality and safety
13 improvements to the historical foundations of racism in medicine. In addition, the AMA's popular
14 "Prioritizing Equity" webinar series grew to 28 episodes, with new features on voting, health
15 equity and reproductive care as a human right.

16
17 The AMA helped launch the "In Full Health Learning and Action Community to Advance
18 Equitable Health in Innovation" initiative, building upon the expertise of 17 external collaborations
19 to create three AMA Ed Hub™ learning modules and the "Equitable Health Innovation Solutions"
20 toolkit.

21
22 Building on the AMA's commitment to diversity, equity and inclusion, the AMA Graduate
23 Medical Education Competency Education Program and the AMA Undergraduate Medical
24 Education Curricular Enrichment Program launched a series of health equity educational courses:
25 "Social Determinants of Health," "Basics of Health Equity," and three courses in the "Racism in
26 Medicine" series.

27
28 First published in March 2022 as part of the AMA's MedEd Innovation Series, "Coaching in
29 Medical Education" quickly sold out. Now in its second printing, this instructor-focused guide
30 outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical
31 education and training books since its release. The AMA also published "Protecting the Education
32 Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to
33 support educators amid extreme stress and which formed the basis of the Educator Well-Being in
34 Academic Medicine book published in December.

35
36 The AMA released a special 175th anniversary edition of its Code of Medical Ethics, and the
37 Journal of the American Medical Association, under the direction of new Editor-in-Chief Kirsten
38 Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical
39 journals. All 12 specialty publications from the JAMA Network™ ranked among the top 10 in
40 journal Impact Factor, with eight ranking in the top three for their respective specialties.

41
42 The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program
43 helped creators of health technology and services utilize the code set for their transformative
44 innovations. The new self-service portal gives physicians the ability to license CPT code sets
45 through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak
46 and ongoing releases for specific COVID-19 vaccines.

47
48 The AMA relaunched its popular Physician Innovation Network digital platform, which now has
49 more than 18,000 collaborators and 30 industry partners, to improve user experience and more
50 effectively connect physicians with technology innovators.

1 *Leading the charge to confront public health crises*

2

3 The AMA expanded its health equity investments with the launch of the Rise to Health: A National
4 Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared
5 solutions for high-impact structural change, and with a \$3 million multi-year investment in
6 Chicago's West Side United, a community-based collaborative that is addressing determinants of
7 health and helping restore economic vitality on the city's West Side.

8

9 The AMA developed a mpox resource page to provide physicians with updated information on
10 testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar
11 detailing the tecovirimat (TPOXX) antiviral. And the AMA collaborated on the annual "Get My
12 Flu Shot" campaign, with a specific focus on reaching Black and Latinx populations and kept
13 physicians and the public up to date on the latest pandemic developments, including therapeutics
14 and the importance of staying up to date with COVID-19 vaccines.

15

16 To close the gap in blood pressure management training within medical schools, the AMA
17 launched a three-part eLearning series, supported by a one-year grant program to monitor the
18 impact of this new training. AMA policy guidance led to four states increasing access to Medicaid
19 programs for self-measured blood pressure by covering home-use devices and clinical support
20 services. Additionally, the AMA also helped train more than 100 community health workers to
21 help Chicago's West Side residents more accurately measure their blood pressure at home.

22

23 The AMA's Substance Use and Pain Care Task Force continues to advance evidence-based
24 recommendations for policymakers and physicians to help end the nation's drug-related overdose
25 and death epidemic. The AMA and Manatt Health 2022 State Toolkit identifies more than 400 state
26 laws, regulations, and policy guidance to help end the nation's drug overdose epidemic.

27

28 The AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and
29 thoughtful structure to engage AMA employees in public service work aligned with the
30 organization's values and goals. The program has strategically integrated with the Center for
31 Health Equity's strategic plan to support healthy, thriving, equitable communities. Thirty percent of
32 AMA employees, representing every business unit and office location, supported nearly 80
33 organizations and donated \$160,000 to community partners.

34

35 *Membership*

36

37 Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small
38 decrease in overall membership (due to a drop in student numbers), but physician membership
39 remained steady. Overall, the organization's advocacy efforts and mission activities were supported
40 by another strong year of financial performance.

41

42 *EVP Compensation*

43

44 During 2022, pursuant to his employment agreement, total cash compensation paid to James L.
45 Madara, MD, as AMA Executive Vice President was \$1,281,270 in salary and \$1,220,904 in
46 incentive compensation, reduced by \$2,632 in pre-tax deductions. Other taxable amounts per the
47 contract are as follows: \$151,198 distribution from a deferred compensation plan; \$23,484 imputed
48 costs for life insurance, \$24,720 imputed costs for executive life insurance, and \$3,650 paid for an
49 executive physical, and \$3,519 paid for parking and other. An \$81,000 contribution to a deferred
50 compensation account was also made by the AMA. This will not be taxable until vested and paid
51 pursuant to provisions in the deferred compensation agreement. For additional information about
52 AMA activities and accomplishments, please see the "AMA 2022 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-23

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy
2 activities from March 2022 through February 2023. The report is written pursuant to AMA Policy
3 D-490.983, “Annual Tobacco Report.”

4
5 TOBACCO USE AT A GLANCE

6
7 Tobacco control efforts are often heralded as a roadmap for advocates addressing other health
8 behaviors associated with negative health outcomes. The successes of those efforts to reduce the
9 tobacco-related harms cannot be diminished; however, tobacco remains the leading cause of
10 preventable disease, disability, and death in the United States.¹ According to the Centers for
11 Disease Control and Prevention (CDC) tobacco kills more than 480,000 people annually. Based on
12 2020 data, an estimated 31 million U.S. adults smoke cigarettes, and each day 1600 youth under 18
13 years old smoke their first cigarette. More than 16 million people live with at least one disease
14 caused by smoking.²

15
16 *Youth Tobacco Use Associated with Social Determinants of Health Inequities*

17
18 The National Youth Tobacco Survey (NYTS) is a cross-sectional, voluntary, school-based, self-
19 administered survey of U.S. middle and high school students. In 2022, the survey was conducted
20 using an online survey. A total of 28,291 students from 341 schools participated, yielding an
21 overall response rate of 45.2%.³

22
23 An analysis of the 2022 NYTS estimates 3 million (4.5% of middle school students and 16.5% of
24 high school students) currently use any tobacco product including electronic cigarettes (e-
25 cigarettes). E-cigarettes are the most commonly used tobacco product by students. Three percent of
26 middle school students and 14% of high school students reported current use of e-cigarettes. NYTS
27 defines current tobacco use as one or more of any commercial tobacco product on ≥ 1 day during
28 the past 30 days.³

29
30 For the first time since the initial survey in 1999, estimates for Asian, American Indian or Alaska
31 Native (AI/AN), Native Hawaiian or Other Pacific Islander (NH/OPI), and multiracial population
32 groups were provided. The report states, “Whereas AI/AN students reported the highest prevalence
33 of current use of any tobacco product, current use of any combustible tobacco product, specifically
34 cigar and hookah use, was highest among Black students. In addition, current use of any tobacco
35 product was higher among those students identifying as LGB [lesbian, gay, bisexual] or
36 transgender, those reporting severe psychological distress, those with low family affluence, and
37 those with low academic achievement.”³

1 The inequities suggest the impact of the continued aggressive marketing by tobacco companies and
2 e-cigarette manufacturers to specific populations.

3
4 Because of changes in methodology, including differences in survey administration and data
5 collection procedures, the ability to compare estimates from 2022 with those from previous NYTS
6 waves is limited. However, the cross-sectional data provided by the 2022 survey are still valid and
7 informative.³

8 9 *Adult Tobacco Use*

10
11 Adult tobacco use has continued to decline with an estimated 19% of U.S. adults reporting current
12 use of any commercial tobacco product according to the 2020 National Health Interview Survey
13 (NHIS) compared to 21% reported in 2019. NHIS is an annual, nationally representative household
14 survey of the noninstitutionalized U.S. civilian population. Current use is defined by NHIS as
15 having reported use of these products every day or some days at the time of survey. While e-
16 cigarettes are the most common tobacco product of youth, an estimated 80% of adults reported
17 using combustible products (cigarettes, cigars and pipes).⁴

18
19 The CDC report shows inequities in adults who smoke and use tobacco in the U.S. According to
20 the report groups with high rates of smoking include people with lower income and less education,
21 AI/AN adults, residents of the Midwest and South, residents of rural areas, LGB adults, and adults
22 who regularly had feelings of anxiety or depression. Adults who are uninsured or enrolled in
23 Medicaid smoke at more than double the rates of those with private health insurance or Medicare.⁴

24
25 Among all tobacco products, combustible products are the predominate cause of tobacco related
26 morbidity and mortality indicating that policies directed at these products remain a high priority.⁵
27 These policies should focus on providing access to evidence-based treatments for tobacco
28 dependence and disincentives to smoking such as increases in taxes.⁴

29 30 EFFORTS TO ADDRESS TOBACCO CONTROL

31 32 *ALA Releases its 2023 State of Tobacco Report*

33
34 The American Lung Association (ALA) “State of Tobacco Control” report evaluates state and
35 federal policies on actions taken to eliminate tobacco use and recommends proven-effective
36 tobacco control laws and policies. The report provides letter grades to five interventions. At the
37 federal level grades are given for regulation of tobacco products, coverage for smoking cessation,
38 taxes, mass media campaigns and minimum sales age. At the state level the report evaluates
39 smokefree workplace laws, sales of flavored tobacco products, state program funding, tobacco
40 taxes, and access cessation services.

41
42 According to the American Lung Association’s 2023 State of Tobacco Report, the Federal
43 government took major steps toward regulating tobacco products in 2022 but fell short in coverage
44 of quit smoking treatments and increasing federal taxes. The states with the highest overall grades
45 were California, District of Columbia, and Massachusetts. The report shows how widely tobacco
46 policies vary from state to state. For example, some states still allow smoking in workplaces
47 including restaurants and bars, and some states lack Medicaid coverage for tobacco cessation.
48 Alabama, Mississippi, North Carolina, and Texas were states with the most need to enact evidence-
49 based policies.

1 The report also highlights the need to continue funding programs like the CDC's Tips From Former
2 Smokers® (Tips®) campaign launched in 2012. The campaign profiles real people from many
3 different backgrounds living with serious long-term health effects from smoking and secondhand
4 smoke exposure. State level funding for cessation efforts also should be prioritized as well as
5 efforts to provide support for community-level engagements in addressing inequities.⁶

6
7 *AMA Joins with Public Health Groups to Protect Tobacco Regulation and Funding*

8
9 The CDC Office on Smoking and Health (OSH) has a proven track record in developing programs,
10 initiatives and resources that have reduced the social, medical, and economic tolls associated with
11 tobacco in the U.S. Dedicated and increased funding is needed by for OSH to support ongoing
12 research that contributes to the development of innovative interventions in tobacco prevention and
13 cessation.

14
15 In April 2022 the AMA signed on to a letter calling on the House of Representatives
16 Appropriations Committee to increase funding for OSH by \$68.5 million, for a total of \$310
17 million.

18
19 In June 2022, when members of the House of Representative's Committee on Appropriations were
20 reviewing the Agriculture, Rural Development, Food and Drug Administration, and Related
21 Agencies Appropriations bill the public health community raised concerns that the bill would
22 include language weakening FDA's authority over tobacco. The AMA was one of 70
23 organizations, including Federation members American Thoracic Society, American Academy of
24 Pediatrics and American College of Cardiology, who signed a letter to the Committee calling on
25 them to ensure that FDA has the unfettered ability to protect youth from unscrupulous marketing of
26 any and all tobacco products.

27
28 These letters were part of a comprehensive strategy to ensure that the tobacco industry and others
29 have limited influence in weakening the strides made in tobacco control while being prepared for
30 new threats to public health in the future.

31
32 *Supreme Court Upholds California Law Banning Flavored Tobacco Products*

33
34 In 2020, California Governor Gavin Newsom signed Senate Bill 793 into law. This law prohibited
35 the sale of menthol cigarettes and most flavored tobacco products. The law was immediately
36 challenged and thus began a two-year legal battle by R.J. Reynolds who sued the state of California
37 and effectively delayed implementation until the law could be considered in a ballot referendum in
38 2022. In November 2022, California voters overwhelmingly supported the 2020 law with more
39 than 60% voting yes on the referendum.

40
41 R.J. Reynolds and other tobacco entities immediately appealed to the Supreme Court, requesting an
42 emergency injunction against California's law arguing that the Federal Tobacco Control Act
43 prohibited California from enacting its flavored tobacco law. The AMA joined with public health
44 groups and other medical associations in an amicus brief opposing R.J. Reynolds' emergency
45 application. On December 12, the Supreme Court denied the suit and on December 21, California
46 became the second state to ban the sale of flavored tobacco products and menthol cigarettes.
47 Massachusetts was the first state to ban flavors and menthol in 2019.

1 *FDA Takes Steps to Remove Menthol*

2
3 On April 28, 2022, the U.S. Food and Drug Administration (FDA) released two proposed rules on
4 characterizing flavors in tobacco products. One of the proposed rules would ban menthol and all
5 characterizing flavors such as strawberry flavor in cigarettes, and the other proposed rule would
6 prohibit menthol in cigars. This news was treated with great support from public health groups, but
7 it came after years of inaction by the FDA. The long-overdue action follows a lawsuit filed in 2020
8 by the African American Tobacco Control Leadership Council, Action on Smoking and Health,
9 AMA, and National Medical Association.

10
11 According to a Substance Abuse and Mental Health Services Administration study, “85% of non-
12 Hispanic Black and African American adults who smoke prefer menthol cigarettes, and menthol
13 flavoring in cigarettes and e-cigarettes make it easier for youth to initiate smoking.”⁷ “It is
14 estimated that nearly 1 million Americans—and about 230,000 African Americans—would quit
15 smoking within 13 to 17 months of a ban on menthol cigarettes taking effect.”⁸

16
17 FDA has announced that the final rules will be released sometime in 2023. Barring any delay from
18 the anticipated lawsuits from the tobacco industry, products will have to be removed within one
19 year.

20
21 *Congress Closes Loophole in FDA Authority*

22
23 In March, Congress took action to expand the FDA’s regulatory authority over tobacco products
24 using synthetic nicotine. FDA’s authority to regulate nicotine in tobacco products was previously
25 limited to tobacco-derived nicotine. This specificity created a loophole for manufacturers including
26 Puff Bar to reintroduce their e-cigarette with synthetic nicotine when ordered to take their flavored
27 tobacco-derived product off the market. Congress closed this loophole by allowing the FDA to
28 regulate nicotine regardless of the source. Several state and local jurisdictions have already passed
29 similar laws; however, having a federal framework in place allows for a more comprehensive
30 approach.

31
32 Despite this promising measure, the FDA has yet to take significant enforcement actions against
33 companies still selling unauthorized synthetic nicotine products. Tribal, state, local, and territorial
34 governments can and should move forward to implement their own laws where necessary and
35 ensure that synthetic nicotine is included in their tobacco control efforts.

36
37 *FDA and DoJ Take Actions Against Manufacturers*

38
39 Starting in September 2020, all tobacco product manufacturers are required to submit a premarket
40 application and receive authorization from the FDA before introducing a new tobacco product into
41 the market. In accordance with its regulatory authority, the FDA issued warning letters to two
42 brands of e-cigarettes doing business as Puff Bar for “receiving and delivering e-cigarettes”
43 without a marketing authorization order. The agency also issued marketing denial orders for 32
44 premarket tobacco applications, because they “lacked sufficient evidence demonstrating that these
45 flavored e-cigarettes would provide a benefit to adult users that would be adequate to outweigh the
46 risks to youth.”

47
48 In October 2022 the U.S. Department of Justice (DoJ), on behalf of the FDA, filed for permanent
49 injunctions against six e-cigarette manufacturers on behalf of the FDA. According to the FDA, this
50 action represents the first time that the agency has begun injunction proceedings to enforce
51 premarket review requirements under the Federal Food, Drug and Cosmetic Act.

1 Each of the six defendants—Lucky’s Convenience & Tobacco LLC doing business as Lucky’s
2 Vape & Smoke Shop in the District of Kansas; Morin Enterprises Inc. doing business as E-Cig Crib
3 in the District of Minnesota; Seditious Vapours LLC doing business as Butt Out in the District of
4 Arizona; Soul Vapor LLC in the Southern District of West Virginia; Super Vape’z LLC in the
5 Western District of Washington and Vapor Craft LLC in the Middle District of Georgia—illegally
6 manufactured, sold and distributed their products, even after receiving warnings from the FDA.
7
8 The defendants did not submit premarket applications for their e-cigarettes and subsequently
9 received a warning from the FDA. While most of the 300 companies that received warning labels
10 removed their products from the marketplace, the six defendants continued manufacturing,
11 distributing, and selling their products.

¹ Centers for Disease Control and Prevention. (2022, March 17). Current cigarette smoking among adults in the United States. Centers for Disease Control and Prevention. Retrieved March 7, 2023, from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

² Centers for Disease Control and Prevention. (2022, August 22). Fast facts and fact sheets. Centers for Disease Control and Prevention. Retrieved February 22, 2023, from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Ftobacco%2Fdata_statistics%2Ffact_sheets%2Findex.htm

³ Park-Lee, E, Ren, C, Cooper M, et al. Tobacco Product Use Among Middle and High School Students — United States, 2022. *MMWR Morb Mortal Wkly Rep* 2022;71:1429-1435

⁴ Cornelius, M. E., Loretan, C. G., Wang, T. W., Jamal, A., & Homa, D. M. (2022). Tobacco product use among adults — United States, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 71(11), 397–405. <https://doi.org/10.15585/mmwr.mm7111a1>

⁵ US Department of Health and Human Services. The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. <https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/>

⁶ www.lung.org. (n.d.). Retrieved March 3, 2023, from <https://www.lung.org/getmedia/54b62731-072e-4aba-9734-61da097d6a89/State-of-Tobacco-Control-2023>

⁷ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Substance Abuse & Mental Health Data Archive. National Survey on Drug Use and Health, 2019

⁸ Chung-Hall J, Fong GT, Meng G, et al Evaluating the impact of menthol cigarette bans on cessation and smoking behaviours in Canada: longitudinal findings from the Canadian arm of the 2016–2018 ITC Four Country Smoking and Vaping Surveys *Tobacco Control* 2022;31:556-563.

REPORT 10 OF THE BOARD OF TRUSTEES (A-23)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to “develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (“Center”) in April 2019 and the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (“Plan”) in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and inclusion strategy.”

Discussion: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Conclusion: Despite challenges, including the COVID-19 pandemic, our AMA persevered in efforts to advance equity by continuously engaging in meaningful conversations, and finding innovative ways to connect, learn, and create. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional \$3 million multi-year investment. The AMA continued to promote the art and science of medicine and the betterment of public health, advancing equity and embedding racial and social justice, making significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-23

Subject: American Medical Association Health Equity Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 BACKGROUND

2
3 At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our AMA to
4 “develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track
5 AMA health equity activities” and instructing the “Board to provide an annual report to the House of
6 Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional
7 guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which
8 our AMA will work by advocating for health care access, research, and data collection; promoting equity
9 in care; increasing health workforce diversity; influencing determinants of health; and voicing and
10 modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for
11 Health Equity (“Center”) in April 2019 and the AMA’s Organizational Strategic Plan to Embed Racial
12 Justice and Advance Health Equity for 2021-2023 (“Plan”) in May 2021. In 2022, updated Policy H-
13 65.946 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and
14 inclusion strategy.”

15
16 DISCUSSION

17
18 Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and
19 embedding equity across the organization and beyond. In 2022, the Center continued to collect enterprise-
20 wide equity related work and track progress toward the five strategic approaches detailed in the AMA’s
21 Plan. This report outlines the activities conducted by our AMA during calendar year 2022, divided into
22 five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3)
23 Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial
24 Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

25
26 *Embed Equity*

27
28 Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-
29 racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA’s
30 staff and broader culture, systems, policies, and practices, including training, tools, recruitment and
31 retention, contracts, budgeting, communications, publishing, and regular assessment of organizational
32 change. The following are some of the relevant accomplishments during 2022:

- 33
34 • The AMA engaged 1,000,000 users of health equity-related content on the website, a +43%
35 increase over the prior year, by producing 108 new health equity-related articles or other content,
36 significantly more than any other year. The most consumed content included: (1) “GME –These
37 courses create health equity champions in your Residency Program” (193K users), (2) “2022 a
38 critical year to address the worsening drug overdose crisis” (13K users), (3) “The AMA’s
39 Strategic plan to embed racial justice and advance health equity” (11k users).

- 1 • The AMA incorporated health equity into the annual Medical Student Advocacy Conference
2 (MAC) and the annual Research Challenge, which is the largest national, multi-specialty medical
3 research conference for medical students, residents and fellows, and international medical
4 graduates to showcase and present research. Changes included incorporating customized
5 diversity, equity, and inclusion (DEI) statements in Research Challenge marketing, reducing bias
6 in the Research Challenge abstract review process by removing author names, incorporating
7 subtitles in Research Challenge and MAC training videos, and producing an education session at
8 MAC on redefining social determinants of health in organized medicine.
- 9 • The AMA continued to reflect its commitment to health equity in its messaging, speeches, and
10 announcements on an ongoing basis on various fronts including the All-Employee Meeting,
11 Frontline Communicator Training, Board of Trustees message/media training, and beyond.
- 12 • The AMA produced six Prioritizing Equity episodes (including voting and health and
13 reproductive health care as a human right) and eight podcast episodes (five Stories of Care
14 episodes on health equity and infection control, two LGBTQ-themed episodes, and one episode
15 on embedding racial and health equity in health systems), hosted 2 webinars on social
16 determinants of health and racial and health equity for health systems, and published a STEPS
17 Forward toolkit (Racial and Health Equity: Concrete STEPS for Health Systems) and five health-
18 equity centered issues of the Journal of Ethics (Inequity Along the Medical/Dental Divide,
19 Toward Abolition Medicine, Health Equity in US Latinx Communities, Inequity and Iatrogenic
20 Harm, What We Owe Workers in Health Care Who Earn Low Wages) with a combined 1 million
21 unique journal website visitors during the months of those issues.
- 22 • AMA Councils produced three reports including health equity considerations adopted by the
23 House of Delegates on pandemic ethics, rural public health, and climate change and public health.
24 The Board of Trustees produced two health-equity related reports adopted by the House of
25 Delegates on a [global non-discrimination policy](#) and [language related to discrimination and](#)
26 [harassment](#).
- 27 • AMA staff updated over 50 years of publication illustrations of patients in procedural
28 descriptions for the Current Procedural Terminology (CPT) Pro Book. The 2023 CPT PRO Book
29 will have over 20 illustrations that reflect diversity in skin tones and ethnicity, with plans for
30 more in future years.

31
32 The AMA's employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to
33 operationalize DEI initiatives across the enterprise. Within embedding equity, updates on the AMA's
34 diversity and inclusion strategy include:

- 35
- 36 • All of the AMA's business units (BUs) created their first annual equity action plans.
- 37 • The AMA developed the second phase of its embedding equity curriculum, for launch in 2023, to
38 help staff practically apply inclusive skills.
- 39 • The AMA developed dashboards including demographics of existing staff and new hires, with
40 data included in the annual report to AMA senior management.
- 41 • The AMA continued to diversify its outside counsel legal spend by working with law firms
42 owned by Black attorneys, attorneys of color and/or women, some of whom are members of the
43 National Association of Minority & Women Owned Law Firms (NAMWOLF).
- 44 • The AMA continued efforts toward expanding its vendor base to a more diverse group.
- 45 • The AMA added to its suite of Employee Resources Groups with the launch of the Immigrant
46 Xchange ERG. [ERGs](#)¹ are voluntary, self-coordinating employee-driven groups which are based

¹ Immigrant Xchange joins Access, BEAN (Black Employees, Advocates and Allies Network), InspirASIAN, Pride, Unidos, Veterans Community Resource Group, and Women Inspired Now (WIN).

1 on a constituency or shared interest, and provide community, support and networking
2 opportunities.

- 3 • The AMA continued its partnership with Urban Alliance’s Alumni Internship Program (AIP),
4 which matches graduates of the High School Internship Program with paid 6-week summer
5 internships at the AMA, to help them gain valuable professional experience and earn income to
6 support their future.
- 7 • The AMA committed to improving workplace accessibility including installing auto-operators on
8 doors in Chicago and DC, and reduced size of conference room tables to improve accommodation
9 for mobility devices and other factors.
- 10 • The JAMA Network Equity Action Team (JNEAT) led work including an anonymous pulse
11 survey of staff and bi-monthly newsletters and learning sessions for staff. Webinars attracting
12 over 325 employees included a dialogue with Dilla Thomas on the history of medicine in Chicago
13 through the lens of its marginalized groups, a learning session with Open Books Chicago on
14 literacy levels within Chicago’s marginalized communities, and an interactive practice session for
15 staff to learn about updates and practice applying inclusive language and reporting guidance in
16 medical publication.

17
18 *Build Alliances and Share Power*

19
20 Building strategic alliances and partnerships and sharing power with historically marginalized and
21 minoritized physicians and other stakeholders is essential to advancing health equity. This work centers
22 previously excluded voices, builds advocacy coalitions, and establishes the foundation for true
23 accountability. The following are some of the relevant accomplishments during 2022:

- 24
25 • The AMA continued to sponsor events that engaged historically marginalized audiences,
26 including National Association of Black Journalists (NABJ), National Association of Hispanic
27 Journalists (NAHJ), the Association of LGBTQ Journalists (NLGJA).
- 28 • The AMA completed a community impact plan for improving blood pressure control in
29 collaboration with West Side United (WSU). In October, working with the City Club of Chicago,
30 AMA convened business and civic leaders to highlight the collaboration and the AMA’s
31 additional \$3 million social impact investment, bringing the AMA’s multi-year total investment
32 to \$5 million, with the intention of benefitting Chicago’s 500,000 West Side residents (33%
33 Black, 39% Hispanic or Latino, 21% white). This investment leverages AMA’s new commitment
34 as an anchor mission partner with WSU—adding to a group of collaborators committed to
35 addressing structural inequities, eliminating health disparities and improving economic vitality
36 and educational opportunities in Chicago’s west side communities, which have been devastated
37 by decades of neglect and disinvestment.
- 38 • The national Release the Pressure (RTP) campaign, led by the AMA in collaboration with the
39 American Heart Association, the AMA Foundation, the Association of Black Cardiologists, the
40 Minority Health Institute, and the National Medical Association, was designed to increase
41 awareness of heart health, heart disease and high blood pressure among Black women. The
42 campaign continued momentum in 2022 with over 67,000 video views and almost 31,000
43 pledges.
- 44 • The Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with
45 Morehouse School of Medicine’s Satcher Health Leadership Institute (SHLI), showcased
46 capstone projects of the first cohort of 12 physician fellows at the AMA HOD Interim Meeting
47 and launched the second cohort of 11 physician fellows with intensive training at Morehouse
48 School of Medicine.
- 49 • As part of the Physician Data Collaborative (Collaborative), the AAMC, ACGME and AMA
50 continue to work together to establish best practices for data sharing and collection and reporting

1 standards for sociodemographic data, including race and ethnicity, sexual orientation, gender
2 identity and more. These efforts enable meaningful, collaborative research to better understand
3 the dynamics of the physician workforce continuum. During 2022, the Collaborative agreed on
4 race and ethnicity data collection standards and the addition of a Middle Eastern and North
5 African category (establishing a pilot on the addition of this category), and continued to refine a
6 collaborative research agenda.

- 7 • The AMA participated in or led four meetings with Association of American Medical Colleges
8 (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) about
9 diversifying physician workforce, three ACGME Diversity Officers Forums, two webinars
10 (Enhancing Diversity Among Academic Physicians: Recruitment, Retention and Advancement;
11 Removing barriers and facilitating access: Supporting trainees with disabilities across the medical
12 education continuum), two presentations to Academic Physicians Section (equity, diversity, and
13 belonging activities in medical education; minoritized physician burnout and wellbeing), and
14 three presentations on the implications of the pending Supreme Court decision on *Students for*
15 *Fair Admissions v. Harvard / University of North Carolina*.
- 16 • The AMA provided seven speaking engagements or workshops with organizations that serve
17 historically marginalized communities (including one with AllianceChicago and three with
18 Arizona Alliance, both consortia of Federally Qualified Health Centers, or FQHCs), completed
19 burnout assessments in 32 FQHCs (representing approximately 31% of all burnout assessments
20 during the year), updated demographic questions in burnout assessments, and built a racial bias
21 assessment tool (to be validated in 2023). The AMA piloted the stratification of all burnout
22 assessment data for each health system report for a 3-month period to better understand how it
23 informs systems as well as the limitations of the data.
- 24 • The AMA engaged with Illinois March of Dimes in workgroups on dismantling racism,
25 increasing care access, and engaging communities in private practices to support maternity care
26 deserts.
- 27 • The health equity content on AMA's Ed Hub has established itself as an impetus for institutional
28 memberships and partnerships, with six additional health equity-focused external partners signed
29 and launched during the year (Clinical Problem Solvers, Boston Children's Hospital, American
30 Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, Hope for
31 Justice, and Accreditation Council for Graduate Medical Education or ACGME). The UNC
32 Health Systems recently selected the Ed Hub's "Basics of Health Equity" as required education
33 for their entire medical staff. During the Mpox outbreak, the established relationships with
34 LGBTQ health organizations allowed for swift response with accurate, effective, and
35 destigmatizing education reaching the large Ed Hub audience.
- 36 • The AMA ChangeMedEd initiative implemented grants awarded in November to various
37 recipients, including Kaiser Permanente (Early Assurance: Community College to Medical
38 School) and UC Davis (Learning from Bright Spots in Equitable Grading Practices).
- 39 • The AMA continued its work with organizations representing historically minoritized and
40 marginalized physicians, including Association of American Indian Physicians (AAIP), GLMA,
41 National Council of Asian Pacific Islander Physicians (NCAPIP), National Hispanic Medical
42 Association (NHMA), and National Medical Association (NMA). The AMA concluded a second
43 year of Health Equity Strategic Development (HESD) grants, an investment in these
44 organizations in support of the advancement of their individual organizational mission and
45 strategic goals, and in recognition of the collective impact of their work on the field of medicine.
46 In addition, the Center convened the organizations quarterly, building a crosswalk of shared
47 policy priorities to identify opportunities to build on each other's advocacy in future years. The
48 LGBTQ Advisory Committee has a permanent position for a representative from GLMA on the
49 committee, which allowed for continued regular coordination and collaboration with GLMA. The

1 Minority Affairs Section has permanent positions on its Governing Council for representatives
2 from AAIP, NHMA, and NMA.

- 3 • The Medical Student Section (MSS) Assembly includes delegates from the Association of Native
4 American Medical Students (ANAMS), the Latino Medical Student Association (LMSA), and the
5 Student National Medical Association (SNMA). MSS continued collaborating with the Minority
6 Affairs Section (MAS) to enhance engagement of medical students who are underrepresented in
7 medicine (URM), sending select members of both Governing Councils as ambassadors to the
8 annual conferences of URM medical student societies including SNMA, LMSA and ANAMS.
9 This year, MAS launched its Leader-To-Leader initiative to better align the section's priorities
10 around increasing diversity, equity, inclusion, and representation in the physician workforce.
11 MAS and MSS members worked together to host receptions at the SNMA and LMSA annual
12 conferences where our URM AMA leaders could meet with their elected and appointed leaders to
13 open new lines of communication, to establish informal networks, and to learn more about
14 organizational priorities. In April, MAS supported registration and housing for approximately 10
15 elected leaders of MSS, SNMA, LMSA and ANAMS to attend the annual Leadership Summit on
16 Health Disparities, to foster network expansion, informal networking, and educational
17 opportunities among these future doctors. The MAS and MSS Governing Councils also hosted a
18 meeting in November to specifically convene URM medical student leaders who attended our
19 Interim Meeting in Honolulu.
- 20 • The AMA formalized its collaboration with Stanford supporting research using AMA data to
21 explore the effects of the COVID pandemic on international medical graduate (IMG) physicians,
22 patterns of care provided by IMGs across the U.S., and their role in providing patient care for
23 underserved communities during COVID-19.

24 *Push Upstream*

25
26 Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural
27 and social drivers of health and inequities, dismantle systems of oppression, and build health equity into
28 health care and broader society. The following are some of the relevant accomplishments during 2022:
29

- 30 • On the international stage, the World Medical Association (WMA) General Assembly adopted a
31 new policy to address racism in medicine, to which the AMA contributed substantial language
32 and support, based largely on HOD policy. The AMA has also been leading the ongoing revision
33 of a seminal WMA document, the Declaration of Helsinki Ethical Principles for Medical
34 Research Involving Human Subjects, prioritizing diverse perspectives and issues of equity, such
35 as ethical research in vulnerable populations. Finally, the AMA has continued centering equity in
36 other WMA policy revisions, including addressing the disproportionate impact of forced
37 sterilization on certain groups.
- 38 • The AMA was a powerful voice on reproductive health following the Supreme Court's *Dobbs*
39 decision in June and continued to be visible on this topic in the media and speeches and published
40 numerous AMA Viewpoints on topics important to health equity including LGBTQ health, pulse
41 oximeters, and Black maternal health.
- 42 • In cases ranging from COVID-19 standards of care and firearm regulations to climate change and
43 transgender rights, the AMA continued to fight for physicians and patients in state and federal
44 courts. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v.*
45 *HHS*, which forced the federal government to take the first steps toward banning menthol
46 cigarettes. In support of the consideration of race in higher education admissions, the AMA
47 joined an AAMC-led U.S. Supreme Court [amicus brief](#) in the *Students for Fair Admission v.*
48 *Harvard* and *Students for Fair Admission v. University of North Carolina* cases. Together with
49 the American Academy of Pediatrics, the AMA submitted an [amicus brief](#) urging the U.S.

1 Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the
 2 U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA
 3 joined numerous briefs promoting access to reproductive care and opposing government
 4 interference in the patient-physician relationship.

- 5 • The AMA now looks at every advocacy issue with an eye towards its impact on historically
 6 marginalized and minoritized communities. The AMA issued more than 175 advocacy letters to
 7 policymakers, and more than 40 percent of those were directly related to our health equity work.
- 8 • AMA advocated in many ways for policies to advance health equity including:
 - 9 ○ Securing legislation extending telehealth payment and regulatory flexibilities through the
 10 end of 2024, including audio-only telephone visit services. The AMA also launched
 11 model legislation that states can use to advance telehealth coverage and policies.
 - 12 ○ Supporting maternal and child health. The AMA developed new model state legislation
 13 to support maternal and child health in partnership with leading medical societies and
 14 national organizations. The model bill is part of a national campaign to support pregnant,
 15 postpartum and parenting individuals, newborns, children and families affected by
 16 substance use disorders. The AMA supported 27 states and DC in extending Medicaid
 17 coverage to 12 months postpartum and secured a permanent option to support states in
 18 the Consolidated Appropriations Act of 2023 (CAA).
 - 19 ○ Securing key provisions of the Mainstreaming Addiction Treatment (MAT) Act (such as
 20 repealing the X-waiver requirement for buprenorphine prescribing) in the CAA, revisions
 21 to CDC guidelines for prescribing opioids that emphasize the need to treat patients as
 22 individuals, Food and Drug Administration (FDA) policy allowing harm reduction
 23 organizations to more easily obtain naloxone to prevent overdose deaths, and a Drug
 24 Enforcement Administration (DEA) commitment to working for permanent availability
 25 of medication assisted treatment based on telehealth visits. The AMA also helped
 26 multiple states enact legislation to decriminalize fentanyl test strips and other drug testing
 27 supplies and equipment, acknowledging the annual more than 100,000 deaths are
 28 primarily due to illicitly manufactured fentanyl and fentanyl analogues.
 - 29 ○ The AMA Substance Use and Pain Care Task Force continued to advocate to reduce
 30 health care inequities, including those that disproportionately affect historically
 31 minoritized and marginalized communities. Reports from the Task Force and those
 32 conducted with Manatt Health make clear that reversing the nation's overdose and death
 33 epidemic must directly address structural barriers and social determinants of health. The
 34 Task Force continues to gather input from member organizations Association of
 35 American Indian Physicians, National Hispanic Medical Association and National
 36 Medical Association.
 - 37 ○ Supporting multiple state efforts to enact legislation to strengthen mental health and
 38 substance use disorder parity laws. These include requiring payers to demonstrate
 39 compliance with parity laws and for state departments of insurance and attorneys general
 40 to investigate payers' compliance.
 - 41 ○ The AMA and several collaborators sent a [letter](#) to Attorney General Merrick Garland
 42 urging the Department of Justice to investigate the threats of violence against physicians,
 43 hospitals and families of children for providing and seeking [evidence-based gender-](#)
 44 [affirming care](#). The organizations also call on technology platforms to do more to stop the
 45 rhetoric that often incites threats or acts of violence and has led to harassment campaigns
 46 across the country, much of it directed at children's hospitals and the physicians and staff
 47 who provide care.
 - 48 ○ Highlighting inequities in Medicare Advantage including quality and administrative
 49 barriers. In a [letter](#) to the United States Department of Health and Human Services
 50 (HHS), the AMA noted that Black, Asian, and Latino enrollees sign up for Medicare
 51 Advantage (MA) at higher rates than white enrollees but tend to be in plans with lower

1 quality ratings. Kaiser Family Foundation data show that nearly all (99 percent) of MA
 2 enrollees are in plans that require prior authorization (PA) for some services, up from 80
 3 percent in 2018. Institute for Patient Access data show that patients with chronic
 4 conditions who identify as Black or Latino experience insurance claim rejections at least
 5 40% more often than white patients, going on to experience more emergency room visits
 6 and hospitalizations. The AMA helped move a bipartisan House bill to reform prior
 7 authorization for Medicare Advantage plans, H.R. 3173, the “Improving Seniors’ Access
 8 to Care Act,” passed via voice vote, and a companion Senate bill now with 51 co-
 9 sponsors.

- 10 ○ Developing principles for Medicare physician payment reform endorsed by more than
 11 120 medical societies, which incorporate concepts to advance equity and reduce
 12 disparities.
- 13 ○ Cosigning a letter in conjunction with over 60 national medical specialty, hospital and
 14 patient organizations urging the [House](#) and [Senate](#) Judiciary Committees to pass the
 15 “Conrad State 30 and Physician Access Reauthorization Act,” which would reauthorize
 16 the Conrad 30 waiver policy for an additional three years, to ensure international medical
 17 graduates (IMGs) can continue to play a pivotal role in greater access to health care.
- 18 ○ Submitting a [Statement for the Record](#) to the U.S. House of Representatives Committee
 19 on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing
 20 entitled “Is there a Doctor in the House? The Role of Immigrant Physicians in the US
 21 Healthcare System.” Additionally, the AMA submitted a [Statement for the Record](#) to the
 22 U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the
 23 hearing entitled, “Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health
 24 Care Workforce.”
- 25 ○ The AMA continues to support laws that prohibit so-called conversion therapy. We
 26 successfully supported the Oklahoma State Medical Association in opposing a bill that
 27 would have protected conversion therapy and worked with the AMA’s Advisory
 28 Committee on LGBTQ+ issues to update and disseminate an issue brief summarizing the
 29 medical literature demonstrating the harm caused by conversion therapy.
- 30 ○ Supporting a Dear Colleague letter to the FDA Commissioner urging the end of the
 31 blanket three-month blood donation deferral period for men who have sex with men. The
 32 Dear Colleague letter was ultimately cosigned by nearly 150 members of Congress. The
 33 FDA has signaled that it will continue existing flexibilities.
- 34 ● Every bi-weekly issue of the AMA’s Advocacy Update includes at least one article related to our
 35 health equity work. Equity-related episodes of the AMA’s Advocacy Insights webinar series,
 36 such as the limited time Public Service Loan Forgiveness Program waiver, the future of
 37 telemedicine, and the impact of the nation’s drug overdose epidemic on children and adolescents,
 38 have had significant participation (hundreds of attendees) and engagement (30+ questions) each
 39 session.
- 40 ● The AMA launched a bi-monthly health equity newsletter and the Federation Equity Exchange,
 41 attracting dozens of attendees each month for state and specialty societies to share promising
 42 practices.
- 43 ● This is the first year covered by the AMA’s annual Health Equity in Organized Medicine Survey.
 44 The survey seeks to understand the specific actions that Federation organizations are taking or
 45 contemplated taking to advance health equity, gather shareable successes stories, and
 46 confidentially identify barriers and resource needs.
 - 47 ○ Eighty organizations completed the survey: half (n=40) were specialty societies, about 1
 48 in 3 (n=25) were state and District of Columbia associations, and about 1 in 5 (n=15)
 49 were local associations.
 - 50 ○ Most organizations (70%) indicated that health equity was a strategic priority.

- 1 ○ Most organizations were aware of the AMA’s Organizational Strategic Plan to Embed
2 Racial Justice and Advance Health Equity (85%), and the AMA and AAMC’s Advancing
3 Health Equity: A Guide to Language, Narrative and Concepts (54%). Among the
4 organizations that were aware, about half referenced or used the materials. More than half
5 (n=44) indicated they provided equity training to staff and leadership.
6 ○ More than 1 in 3 (n=30) organizations indicated they had identified historical harms in
7 their organization’s policies and practices, and 30% of organizations indicated that they
8 have taken action to address past harms caused by their organization.
9 ○ Note: All results are preliminary. The survey results are still being analyzed, with a full
10 summary planned for later in 2023.
- 11 ● The JAMA Network published over 632 articles on topics related to equity, diversity, and
12 inclusion, viewed in full text 4 million times.
 - 13 ● AMA staff contributed to at least 10 publications in related to health equity.
 - 14 ● The AMA’s Ed Hub published an unprecedented volume of health equity content (78 activities),
15 with usage of equity-related content exceeding the prior year (124,374 engagements; 21,625
16 course completions). One highlight included: undergraduate / graduate (UME/GME) and
17 continuing medical education (CME) versions of the Historical Foundations of Racism modules
18 were published, as well as adapted versions accessible for UME and GME curricular
19 enhancement program (UCEP/GCEP) members and individual learners: Medical Mistrust and
20 Medical Distrust; Pain and Racism in Medicine and Health Care. In addition, the AMA led 4
21 presentations at health care meetings demonstrating educational best practices for integration of
22 equity.
 - 23 ● The AMA concluded its year-long Peer Network learning collaborative, led by AMA with The
24 Joint Commission (TJC) and Brigham and Women's Hospital as key collaborators, positively
25 influencing the development of TJC equity accreditation standards for health systems.
 - 26 ○ The pilot program of 49 learning sessions included more than 40 participants from eight
27 health systems, of which 3 were AMA group members, graduating the health systems
28 into a Quality Safety and Equity Network integrated into the Physician Innovation
29 Network.
 - 30 ○ Successes of over 26 new improvement practices implemented by the health system
31 teams included embedding a bias/discrimination question into safety reporting to track
32 and take action on equity-related harm events, incorporating fundamental data collection
33 tools to stratify data sets by race, ethnicity, and language (REAL), improving on
34 disability, sexual orientation and gender identity (SOGI) data collection, developing
35 educational content to better equip staff on how to identify inequities, bringing together
36 multidisciplinary stakeholders across the system to identify improvements that will result
37 in better patient and staff experience and outcomes, and incorporating health equity into
38 the development and implementation of a racial equity plan.
 - 39 ○ At mid-year, survey respondents agreed or strongly agreed that the quality of the Peer
40 Network was excellent (100%) and that it equipped them to advance health equity,
41 strengthened their knowledge of inequities, and empowered them to dismantle structural
42 racism (>80%).
 - 43 ○ Products included creating seven Ed Hub modules with CME and a Prioritizing Equity
44 episode highlighting the work of two group member health systems, Atlantic Medical
45 Group and Ochsner Health.
 - 46 ○ The Peer Network was covered in 37 articles with over 10 million views.
 - 47 ● The AMA laid the groundwork for Rise to Health: A National Coalition for Equity in Health
48 Care, an effort that unites individuals and organizations in shared solutions for high-impact
49 structural change. The Coalition, co-led by the AMA and the Institute for Healthcare
50 Improvement (IHI), secured other collaborators including Race Forward, Groundwater Institute,

1 the American Hospital Association (AHA), the National Association of Community Health
2 Centers (NACHC), Association of Health Insurance Plans (AHIP), the Council of Medical
3 Specialty Societies (CMSS), Policy Link, and HealthBegins, with a general audience launch
4 planned for 2023.

- 5 • The AMA expanded its social impact investments with an additional \$3 million multi-year
6 investment in West Side United (WSU), a community-based collaborative that is addressing
7 determinants of health and helping restore economic vitality on the Chicago's west side.
 - 8 ○ This new investment builds on the AMA's initial \$2 million investment in 2020 and will
9 continue to support WSU's multi-pronged social impact investing approach. WSU-
10 coordinated impact investing is done in partnership with community development
11 financial institutions (CDFIs) to help provide much-needed capital to foster economic
12 opportunity, revitalize neighborhoods and support community transformation. AMA's
13 renewed commitments will lead to more investments in affordable housing, healthy food
14 options, job creation projects and educational programs.
 - 15 ○ To date, WSU partners have invested a combined \$177 million in Chicago's West Side
16 neighborhoods through local procurement, small business grants, and impact investing,
17 including the AMA's 5-year, \$5 million investment. Since 2018, the collaborative's
18 funding has contributed to approximately 475 low-interest loans, including entrepreneurs,
19 small businesses, and community-based organizations. CDFIs leveraged these
20 investments for an additional \$28 million to support the west side community and
21 business projects. The WSU investments also resulted in the creation and preservation of
22 420 housing units, as well as the construction and preservation of more than 34,000
23 square feet of non-profit and commercial real estate projects. Additionally, these
24 investments have supported 432 construction jobs, preserved 64 local jobs, and created
25 126 community employment opportunities.
- 26 • In collaboration with West Side United and West Side Health Equity Collaborative, the AMA,
27 trained more than 100 community health workers. In addition, the AMA MAP BP program was
28 implemented and demonstrated success in improving blood pressure control at Cook County
29 Health, a large health care organization serving mostly patients from historically marginalized
30 communities.

31 *Ensure Equity in Innovation*

32 The AMA is committed to ensuring equitable health innovation by embedding equity in innovation,
33 centering historically marginalized and minoritized people and communities in development and
34 investment, and collaborating across sectors. The following are some of the relevant accomplishments
35 during 2022:

- 36 • The AMA launched the In Full Health Learning & Action Community to Advance Equitable
37 Health Innovation initiative which seeks to provide a framework for shared understanding and a
38 community for stakeholders committed to learning and action to center equity within their health
39 innovation investment, development, and purchasing efforts by committing resources to
40 innovations created by, with, and that measurably improve health and do no harm for Black,
41 Latino, Indigenous, communities of color, women, LGBTQ+ communities, people with
42 disabilities, people with low income, rural communities, and other communities historically
43 marginalized by the health industry. The initiative established an external advisory group and
44 published Principles for Equitable Health Innovation.
- 45 • The AMA completed a health equity assessment on Verifi Health Self-Measured Blood Pressure
46 (SMBP), an app for remote blood pressure monitoring, and continues to build features into the
47 product that promote health equity.

- The AMA created a prototype Social Needs Administrative Coder (SNAC) and began a Voice-of-the-Customer campaign across societies, technology vendors, state level entities, health insurers, community organizations and health information exchanges to better understand the need for consistent coding of health-related social needs (HRSN) screening data into nationally accepted codesets like ICD-10-CM.

Foster Truth, Racial Healing, Reconciliation, and Transformation

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2022:

- The 175th anniversary workgroup included AMA archivists as key stakeholders, supporting truth and reconciliation, through development of historical research for programming and educational modules and networking with other medical association professionals looking to examine their histories in this way.
- The AMA began creating a charter and identifying potential participants for the Truth, Reconciliation, Healing, and Transformation Advisory Committee called for by the AMA House of Delegates, so the committee can commence work in 2023.
- AMA staff engaged in educational sessions and community events including: AMA History/Transformative Narrative, Guide to Allyship, Time for Personal Reflection, Liberation Health: Allyship, My Hood / My Block, My City Event, Color of Care Screening and Breakouts, ERG Review & Recruitment, Gardeneers Event, Women Inspired Now (WIN) Reproductive Rights Session and Discussion. One session was a deeper look at the history of work toward reproductive justice within the AMA, findings from qualitative research with patients who have received obstetric, gynecological, and related care, and policy-related implications for maternal health given recent federal level court and legislative actions, state politics, transitional care, contraceptive access for patients, providers, and public health. A Reproductive Justice panel featured obstetrics and gynecology experts as guests, and opening remarks provided by former AMA President Patrice Harris, MD, MPH.
- Dilla Thomas was invited to speak to staff on the Black History of Medicine in Chicago. He titled the event, "Everything Dope Comes from Chicago: A Look into the History of Chicago in Medicine Through the Lens of its Marginalized Groups."

Challenges and Opportunities

As cities and states across the nation updated social distancing guidance, staff returned to AMA offices and began adjusting to new hybrid schedules which required an additional layer of planning and coordination. This required strategizing innovative ways to build connections and foster engagement in a new work environment.

Commonly noted challenges to advancing health equity work included: 1) limited staff time and capacity, resource constraints, and competing priorities with tight deadlines; 2) varying levels of understanding of health equity, with persistence of some common narratives that sustain inequity; 3) still fledgling structures and processes for cross-enterprise dialogue, coordination, and reporting on initiatives and measures; and 4) the capacity, infrastructure, and time needed to develop external collaborations. While turnover was mentioned as a challenge to sustaining the health equity work, in some cases the scarcity of open positions posed challenges to increasing diversity in promotion.

1
2 Prioritizing and matching workload to capacity were mentioned as essential in avoiding contributing to
3 burnout. Additional curriculum and sessions that foster conversations and self-reflection to further
4 understanding and undoing harms in a psychologically safe space require substantial time, timeliness,
5 skilled facilitators, and openness and commitment from team leaders. Additional structures and processes
6 that support transparent sharing of goals, planning, resources, implementation, and accountability across
7 teams and with external collaborators can help bring focus to priorities and promote sustainability.

8
9 CONCLUSION

10
11 AMA staff were asked for their most prominent equity-related accomplishments, and not everything
12 submitted could be included in this report, so the above represents a fraction of the work completed in
13 2022. The AMA increased engagement of health equity content to 1,000,000 website users, including
14 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least
15 two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to
16 health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social
17 impact investments with an additional \$3 million multi-year investment. Overall, the AMA has made
18 significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-23

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980,
2 “Informal Inter-Member Mentoring,” was adopted. As reported at the 2022 Interim Meeting (Board
3 Report 6), last year our AMA convened on an ad hoc basis a Mentorship Steering Committee
4 consisting of representatives from each of the AMA sections. This group was charged with
5 identifying mentorship opportunities and best practices within individual sections and more broadly
6 across the organization. The Committee’s key conclusion was that the AMA should create
7 informal, organic opportunities for mentors and mentees to identify one another and connect, as
8 opposed to establishing more formal programs with assigned mentors/mentees.

9
10 The Committee’s discussions prompted a variety of mentorship initiatives of this connective nature
11 within the sections in 2022, including for example:

- 12
13 • The Women Physicians Section implemented a “speed mentorship” event that connected
14 members in small group discussions with facilitators versed in career-building topics.
15
- 16 • The Young Physicians Section hosted a “leadership boot camp” for young physician
17 members interested in pursuing leadership opportunities beyond the YPS and throughout
18 the AMA.
19
- 20 • The Minority Affairs Section hosted a webinar and networking reception to engage and
21 build connections among current and future MAS and AMA leaders from minoritized and
22 marginalized backgrounds.
23

24 While many individual sections have instituted informal mentorship opportunities designed
25 primarily to connect members, with others in the works, cross-sectional and broader organizational
26 mentorship initiatives have remained elusive, largely due to issues of scalability. In 2023, a
27 reconstituted Mentorship Steering Committee representative of the broad swath of AMA member
28 backgrounds and experiences will be reconvened to continue consideration of opportunities to
29 connect members for mentorship purposes outside the confines of any particular section. Your
30 Board will continue to provide updates via HOD implementation status documents as this work
31 proceeds.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-23

Subject: Medical Community Voting in Federal and State Elections
(Resolution 616-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 Resolution 616 “Medical Student, Resident/Fellow, and Physician Voting in Federal, State and
2 Local Elections,” was adopted at the AMA House of Delegates’ 2022 Annual Meeting. Per the first
3 resolve of Resolution 616, now AMA Policy D-65.982:

4
5 Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows and medical
6 students in federal and state elections without regard to political party affiliation or voting
7 record, as a step towards understanding political participation in the medical community.

8
9 This report completes the request for such a study.

10
11 EXISTING RESEARCH ON PHYSICIAN VOTING TRENDS AND BEHAVIOR

12
13 The consensus conclusion of publicly available studies and analysis addressing physician voting is
14 that physicians consistently vote at lower rates than the general public. Three such reports that help
15 uphold this conclusion are “Trends in Physician Voting Practices in California, New York, and
16 Texas, 2006-2018”¹ by Hussain Lalani, MD, MPH, et al., published in *JAMA Internal Medicine*
17 2021; “Voting Behavior of Physicians and Healthcare Professionals”² by Rachel Solnick, MD,
18 MSc, et al., published in the *Journal of General Internal Medicine* 2020; and “Do Doctors Vote?”³
19 by David Grande, MD, MPA, et al., published in the *Journal of General Internal Medicine* 2007.
20 Through modeling analysis incorporating a variety of publicly available and commercially acquired
21 data, the authors of these studies found physicians voting anywhere from 9 to more than 12 percent
22 less than the general public going back to 2002.

23
24 Lalani et al. looked at the states with the highest physician populations in their study. Their finding
25 that physicians who were eligible to vote did so at rates at least 9 percent less than the general
26 population takes into account data as recent as 2018. The authors offer their proposed reasons as to
27 why physician turnout was lower, including fear of appearing “political” as well as other
28 “administrative and psychological barriers.” However, it should be noted that Lalani et al.
29 acknowledge that this reasoning is speculative and that the true source(s) of limited physician
30 engagement in voting is “unclear” as well as the possible link between physicians who register to
31 vote and those who actually turn out to vote.

32
33 In their study, Solnick et al. looked at physicians as well as other health care professionals
34 including dentists, nurses, physician assistants and pharmacists and found that they also
35 consistently voted at rates lower than the general public, although except for dentists somewhat
36 higher than physicians. The researchers based their findings on a biennial nationally representative
37 household survey that collects self-reported or household member-reported voting rates and
38 behavior from congressional and presidential elections. They estimated physicians voting at
39 approximately 12 percent below that of the public. The authors further found that 70 percent of

1 physicians who were either not registered to vote or did not vote reported that this was due to being
2 “Too busy, conflicting work or school.” Physicians were 30 percent more likely to vote by mail
3 and 15 percent more likely to vote prior to election day compared to the public. Solnick et al. also
4 examined non-health care related professions as part of this study; specifically, those requiring
5 advanced education and/or training including, postsecondary teachers, chief executives, civil
6 engineers, social workers and lawyers. Solnick et al. found that of these, postsecondary teacher
7 turnout was highest; 14 percent above the general population. The authors suggest that further
8 research examine whether health care professionals voting rates can be improved by Election Day
9 flexible scheduling, health care organization campaigns to emphasize the social value of voting,
10 voter registration drives, and education on mail-in voting.

11
12 Finally, Grande et al. compared adjusted physician voting rates in 1996-2002 congressional and
13 presidential elections with those of lawyers and the general population. Like the others, they found
14 physicians voting at lower rates when compared to the public (8.7 percent lower on average) for
15 each of these elections except in 1996. Lawyers meanwhile had voting rates that were 13.5 percent
16 higher than the public during this same time span. Additionally, Grande et al. noted that these
17 trends occurred even in the face of a renewed commitment at that time to prioritize civic
18 participation and engagement within the medical profession led by multiple medical organizations
19 including the American Medical Association that in 2001 issued its “Declaration of Professional
20 Responsibility Medicine’s Social Contract with Humanity,” which included a commitment to
21 “advocate for...political changes that ameliorate suffering and contribute to human well-being.”⁴

22 23 CONCLUSION

24
25 Apart from the studies referenced in this report, there would seem to be a paucity of in-depth,
26 credible analysis on the issue of physician voter turnout. For the studies examined as part of this
27 report however, it is notable that in each, to the extent that the authors explored possible reasons for
28 why physicians overall voted at lower rates than the general public, their conclusions were
29 speculative. It seems reasonable to conclude that physicians as a group do indeed tend to vote at
30 rates both lower than the general public and lower than that of selected professions requiring
31 advanced education and training. With so little data available and to better inform on the issue, the
32 AMA may consider including questions related to the subject of physician voting habits in future
33 polling projects if appropriate.

¹ Hussain Lalani, et al. “Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018,” *JAMA Internal Medicine* 181, 3 (2021): 397–399. [10.1001/jamainternmed.2020.6887](https://doi.org/10.1001/jamainternmed.2020.6887)

² Rachel Solnick, et al. “Voting Behavior of Physicians and Healthcare Professionals,” *Journal of General Internal Medicine* 36, 1 (2021): 1169–1171. [10.1007/s11606-020-06461-2](https://doi.org/10.1007/s11606-020-06461-2)

³ David Grande, et al. “Do Doctors Vote?” *Journal of General Internal Medicine* 22, 5 (2007): 585–589. [10.1007/s11606-007-0105-8](https://doi.org/10.1007/s11606-007-0105-8)

⁴ American Medical Association, Declaration of Professional Responsibility: Medicine’s Social Contract with Humanity (2001). Accessed February 27, 2023, at <https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility>

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-23

Subject: Amendment to Opinion 4.2.7, “Abortion”

Presented by: Peter A Schwartz, MD, Chair

1 At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the
2 recommendations of Council on Ethical and Judicial Affairs Report 1-I-22, “Amendment to
3 Opinion 4.2.7, ‘Abortion.’” The Council issues this Opinion, which will appear in the next version
4 of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

5

6 E-4.2.7 – Abortion

7

8 Abortion is a safe and common medical procedure, about which thoughtful individuals hold
9 diverging, yet equally deeply held and well-considered perspectives. Like all health care
10 decisions, a decision to terminate a pregnancy should be made privately within the relationship
11 of trust between patient and physician in keeping with the patient’s unique values and needs
12 and the physician’s best professional judgment.

13

14 The *Principles of Medical Ethics* of the AMA permit physicians to perform abortions in
15 keeping with good medical practice. (III, IV)

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

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 02-A-23

Subject: Amendment to Opinion 10.8, “Collaborative Care”

Presented by: Peter A. Schwartz, MD, Chair

1

2 At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the
3 recommendations of Council on Ethical and Judicial Affairs Report 2-I-22, “Amendment to
4 Opinion 10.8, ‘Collaborative Care.’” The Council issues this Opinion, which will appear in the
5 next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

6

7 E-10.8 – Collaborative Care

8

9 In health care, teams that collaborate effectively can enhance the quality of care for individual
10 patients. By being prudent stewards and delivering care efficiently, teams also have the
11 potential to expand access to care for populations of patients. Such teams are defined by their
12 dedication to providing patient-centered care, protecting the integrity of the patient-physician
13 relationship, sharing mutual respect and trust, communicating effectively, sharing
14 accountability and responsibility, and upholding common ethical values as team members.

15

16 Health care teams often include members of multiple health professions, including physicians,
17 nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers
18 among others. To foster the trust essential to healing relationships between patients and
19 physicians or nonphysician practitioners, all members of the team should be candid about their
20 professional credentials, their experience, and the role they will play in the patient’s care.

21

22 An effective team requires the vision and direction of an effective leader. In medicine, this
23 means having a clinical leader who will ensure that the team as a whole functions effectively
24 and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By
25 virtue of their thorough and diverse training, experience, and knowledge, physicians have a
26 distinctive appreciation of the breadth of health issues and treatments that enables them to
27 synthesize the diverse professional perspectives and recommendations of the team into an
28 appropriate, coherent plan of care for the patient.

28

29 As clinical leaders within health care teams, physicians individually should:

30

31 (a) Model ethical leadership by:

32

33 (i) Understanding the range of their own and other team members' skills and expertise and
roles in the patient's care

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- 1 (ii) Clearly articulating individual responsibilities and accountability
2
3 (iii) Encouraging insights from other members and being open to adopting them and
4
5 (iv) Mastering broad teamwork skills
6
7 (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and
8 commitment to continuous improvement.
9
10 (c) Help clarify expectations to support systematic, transparent decision making.
11
12 (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in
13 which each member's opinion is heard and considered and team members share
14 accountability for decisions and outcomes.
15
16 (e) Communicate appropriately with the patient and family, respecting the unique relationship
17 of patient and family as members of the team.
18
19 (f) Assure that all team members are describing their profession and role.
20
21 As leaders within health care institutions, physicians individually and collectively should:
22
23 (g) Advocate for the resources and support health care teams need to collaborate effectively in
24 providing high-quality care for the patients they serve, including education about the
25 principles of effective teamwork and training to build teamwork skills.
26
27 (h) Encourage their institutions to identify and constructively address barriers to effective
28 collaboration.
29
30 (i) Promote the development and use of institutional policies and procedures, such as an
31 institutional ethics committee or similar resource, to address constructively conflicts within
32 teams that adversely affect patient care.
33
34 (j) Promote a culture of respect, collegiality and transparency among all health care personnel.
35 (II, V, VIII)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 03-A-23

Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

1 At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the
2 recommendations of Council on Ethical and Judicial Affairs Report 3-I-22, “Pandemic Ethics and
3 the Duty of Care.” The Council issues this Opinion, which will appear in the next version of AMA
4 PolicyFinder and the next print edition of the *Code of Medical Ethics*.

5
6 RECOMMENDATION

7
8 E-8.3 – Physician Responsibility in Disaster Response and Preparedness

9
10 Whether at the national, regional, or local level, responses to disasters require extensive
11 involvement from physicians individually and collectively. Because of their commitment to
12 care for the sick and injured, individual physicians have an obligation to provide urgent
13 medical care during disasters. This obligation holds even in the face of greater than usual risks
14 to physicians’ own safety, health, or life.

15
16 The duty to treat is foundational to the profession of medicine but is not absolute. The health
17 care work force is not an unlimited resource and must be preserved to ensure that care is
18 available in the future. For their part, physicians have a responsibility to protect themselves, as
19 well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So
20 too, health care institutions have responsibilities to support and protect health care
21 professionals and to apportion the risks and benefits of providing care as equitably as possible.

22
23 Many physicians owe competing duties of care as medical professionals and as individuals
24 outside their professional roles. In a public health crisis, institutions should provide support to
25 enable physicians to meet compelling personal obligations without undermining the
26 fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to
27 allow the physician to honor both obligations are not feasible, it may be ethically acceptable for
28 a physician to limit participating in care, provided that the institution has made available
29 another mechanism for meeting patients’ needs. Institutions should strive to be flexible in
30 supporting physicians in efforts to address such conflicts. The more immediately relevant a
31 physician’s clinical expertise is to the urgent needs of the moment and the less that alternative
32 care mechanisms are available, the stronger the professional obligation to provide care despite
33 competing obligations.

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1 With respect to disaster, whether natural or manmade, individual physicians should:
2

3 (a) Take appropriate advance measures, including acquiring and maintaining appropriate
4 knowledge and skills to ensure they are able to provide medical services when needed.
5

6 Collectively, physicians should:
7

8 (b) Provide medical expertise and work with others to develop public health policies that:
9

10 (i) Are designed to improve the effectiveness and availability of medical services during a
11 disaster

12 (ii) Are based on sound science

13 (iii) Are based on respect for patients
14

15
16 (c) Advocate for and participate in ethically sound research to inform policy decisions.
17 (V, VI, VII, VIII)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 06-A-23

Subject: Use of De-Identified Patient Information
(D-315.969)

Presented by: Peter A. Schwartz, MD, Chair

1 Policy [D-315.969](#), “Research Handling of De-Identified Patient Data,” adopted in November 2021
2 directs the Council on Ethical and Judicial Affairs (CEJA) to “consider re-examining existing
3 guidance relevant to the confidentiality of patient information, striving to preserve the benefits of
4 widespread use of de-identified patient data for purposes of promoting quality improvement,
5 research, and public health while mitigating the risks of re-identification of such data.”
6

7 This informational report summarizes CEJA’s research and deliberations to date and direction of
8 further inquiry.
9

10 DO YOU KNOW WHERE YOUR PATIENTS’ DATA ARE TONIGHT? 11

12 An extraordinary variety of data are now regularly collected by multiple entities and stakeholders,
13 for multiple—and potentially discrepant—purposes:
14

15 The last few decades have witnessed the creation of novel ways to produce, store, and
16 analyse data, culminating in the emergence of the field of data science, which brings
17 together computational, algorithmic, statistical and mathematical techniques towards
18 extrapolating knowledge from big data. . . . The availability of vast amounts of data in
19 machine-readable formats provides an incentive to create efficient procedures to collect,
20 organise, visualise and model these data. . . . Researchers across all disciplines see the
21 newfound ability to link and cross-reference data from diverse sources as improving the
22 accuracy and predictive power of scientific findings and helping to identify future
23 directions of inquiry, thus ultimately providing a novel starting point for empirical
24 investigation [1].
25

26 As one scholar has noted, in this new data landscape “it is almost impossible to perform most daily
27 activities without revealing personal information and providing fodder for data brokers and big data
28 organizations, whether they are public or private” [2]. Data that in themselves are not traditionally
29 categorized as “medical” or “health related” can still yield information about health status—for
30 example, predictive analysis of data about customers’ purchases enabled Target “to identify about
31 25 products that, when analyzed together, allowed the company to assign each shopper a
32 “pregnancy prediction” score, and even to predict the shopper’s due date [3].
33

34 The ease with which data from multiple sources within and outside medicine can now be linked
35 and cross-referenced significantly exacerbates challenges of protecting patient privacy and the
36 confidentiality of health information. The council has come to recognize that it should extend its
37 analysis beyond research use of patient information to questions of what role physicians and health

1 care institutions can and should play in protecting patients' interests in how their information is
2 shared and used more broadly.

3 4 WHY PROTECT PRIVACY/CONFIDENTIALITY?

5
6 Within the *Code*, Opinion [3.1.1](#), "Privacy in Health Care," distinguishes four aspects of privacy:

7
8 personal space (physical privacy), personal data (informational privacy), personal choices
9 including cultural and religious affiliations (decisional privacy), and personal relationships
10 with family members and other intimates (associational privacy).

11
12 The *Code* does not explicitly examine whether personal medical or health information are ethically
13 distinct from other kinds of personal information (e.g., financial records) or in what way. Current
14 guidance treats the importance of protecting privacy in all its forms as self-evident, holding that
15 respecting privacy in all its aspects is of fundamental importance, "an expression of respect for
16 autonomy and a prerequisite for trust" (Opinion [3.1.1](#)).

17
18 In the context of information technology, van den Hoven identifies the following concerns with
19 respect to protecting personal data (medical or other):

- 20
21 • Prevention of harm
22 • Commodification of and asymmetry in power to control personal information
23 • Informational injustice and discrimination
24 • Encroachment on moral autonomy and human dignity [4]

25
26 Price and Cohen observe that violations of privacy can result in both harm—tangible negative
27 consequences, such as discrimination in insurance or employment or identity theft—and in wrongs
28 that occur from the fact of personal information being known without the subject's awareness, even
29 if the subject suffers no tangible harm:

30
31 One may be wronged by a privacy breach even if one has not been harmed. For example,
32 suppose that an organization unscrupulously or inadvertently gains access to data you store
33 on your smart phone as part of a larger data dragnet. After reviewing it, including photos
34 you have taken of an embarrassing personal ailment, the organization realizes your data is
35 valueless to them and destroys the record. You never find out this happened. Those
36 reviewing your data live abroad and will never encounter you or anyone who knows you. It
37 is hard to say you have been harmed in a consequentialist sense, but many think the loss of
38 control over your data, the invasion, is itself ethically problematic even absent harm [5].

39
40 They further note that privacy issues can arise not only when data are known, but when data
41 mining enables others to "generate knowledge about individuals through the process of inference
42 rather than direct observation or access" [5]. Recall the anecdote above about Target inferring
43 customers' current health status from data of their purchases over time.

44 45 STRATEGIES FOR PROTECTING PRIVACY/CONFIDENTIALITY

46
47 In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints
48 on the sharing of "protected health information" contained in the medical record—including in the
49 context of relationships within the limited domain of "covered entities" defined in the Act, such as
50 physicians, hospitals, pharmacies, and third-party payers. HIPAA does not cover certain other

1 health-relevant data, especially data generated voluntarily by patients themselves, for example,
2 through the use of health-related apps on devices such as Fitbit or Apple Watch, let alone
3 identifiable data individuals provide to municipal authorities, utilities, or retailers. Information that
4 began in the medical record can take on a new, independent life when linked with personal
5 information widely available through datasets generated outside of health care.

6
7 The current state of data science challenges the prevailing procedural model for protecting privacy:
8 informed consent and de-identification. Yet as Barocas and Nissenbaum have observed, many
9 continue to see these “as the best and only workable solutions for coping with privacy hazards.
10 They do not deny the practical challenges, but their solution is to try harder—to develop more
11 sophisticated mathematical and statistical techniques and new ways of furnishing notice . . .” [6].
12

13 That is, solutions have tended to take the form of technical solutions to enable captured data to be
14 shared, such as the creation of synthetic datasets that replace some or all sensitive or identifying
15 data in an original dataset with a statistically representative sample that preserves statistical
16 properties and relationships among variables of interest [7,8]. Alternative responses have taken the
17 form of proposals for new models of informed consent, such as “blanket consent” (permission to
18 use without restriction), [9] “broad consent” (consent for an unspecified range of future research
19 subject to content or process restrictions), [6,10,11] and “dynamic consent” (the use of
20 personalized, digital interface between participants and researchers that allows participants to
21 “tailor and manage their own consent preferences” over time) [12,13].
22

23 *The Problem of Re-Identification*

24

25 Whether de-identifying datasets truly prevents individual data subjects from being re-identified is
26 increasingly called into question. Removing the 18 identifiers specified in HIPAA can no longer
27 ensure that the data subject cannot be re-identified by triangulation with identifying information
28 from other readily available datasets [14]. The development of ever more robust statistical
29 strategies for de-identifying data in turn prompts the development of yet more robust strategies to
30 enable re-identification [15,16].
31

32 The creation of “synthetic” datasets seeks to offer a technical solution that will enable research
33 with large datasets while protecting privacy by replacing some or all sensitive or identifying data in
34 an original dataset with a statistically representative sample that preserves statistical relationships
35 among variables of interest [17,18]. Inspired by models in manufacturing and engineering, medical
36 “digital twins”—AI technologies that simulate organs or tissues in real time and in relation to an
37 identifiable patient—are proffered as tools to enable highly personalized predictive medicine for
38 the patient whose data have been “twinned” [19,20].
39

40 AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

41

42 Barocas and Nissenbaum contend that “even if [prevailing forms of consent and anonymization]
43 were achievable, they would be ineffective against the novel threats to privacy posed by big data.”
44 [6] A more effective option, Nissenbaum has argued, would understand privacy protection as a
45 function of “contextual integrity,” i.e., that in a given social domain information flows conform to
46 the context-specific informational norms of that domain. Whether a transmission of information is
47 appropriate depends on “the type of information in question, about whom it is, by whom and to
48 whom it is transmitted, and conditions or constraints under which this transmission takes place”
49 [21].

1 Nissenbaum goes on to note that novel information flows, such as those enabled by contemporary
2 data science, should be assessed in reference to how they affect the interests of key parties and
3 whether the distribution of associated benefits, risks, and costs among parties is fair in terms of
4 who enjoys the benefits and who endures the costs. Further, appropriate information flows serve
5 “not merely the interests of individual information subjects, but also contextual, social ends and
6 values—for example, whether information flows with health care achieve the ends and purposes of
7 health care and sustain the values associated with health care.

8
9 An evaluative framework proposed by Nissenbaum and colleagues focuses on components of
10 dataset creation and use:

- 11
- 12 • Creation of the dataset—sourcing, assembling, cleaning, assigning labels [1]
 - 13 • Composition—properties of the dataset (content, mappings among data elements expressed
14 in different modalities) and attributes of the dataset (e.g., demographic representativeness)
 - 15 • Distribution—how the dataset is made available, terms of use, disclaimers
 - 16 • Purpose—what the data set is for, its intended uses, the purposes for which it is optimized
17 [22]
- 18

19 Nissenbaum and colleagues identify ethical values associated with these components, including
20 privacy, autonomy, and the moral legitimacy of the purpose a dataset is created to serve, as well as
21 issues of bias, equity, and accountability, among others.

22
23 This approach has much in common with AMA analysis of conditions for trustworthy augmented
24 intelligence in medicine [23] and offers a starting point for thinking about how CEJA might
25 approach recommendations for ethically responsible management of patient information for
26 purposes of both clinical care and biomedical research.

27
28 **MOVING FORWARD**

29
30 Against this backdrop the council looks forward to continuing its deliberations and to presenting its
31 analysis and recommendations at a future meeting of the House of Delegates.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 07-A-23

Subject: Use of Social Media for Product Promotion and Compensation
(Resolution 025-A-22)

Presented by: Peter A. Schwartz, MD, Chair

1 At its 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution
2 025), “Use of Social Media for Product Promotion and Compensation,” which asked that the
3 American Medical Association (AMA) “study the ethical issues of medical students, residents,
4 fellows, and physicians endorsing non-health related products through social and mainstream
5 media for personal or financial gain.”
6

7 Over the course of its deliberations, the Council on Ethical and Judicial Affairs (CEJA) has
8 identified several relevant issues. These include the volatile and dynamic nature of social media
9 and the fact social media users are able to present themselves as a product, promoting themselves
10 and/or attempting to influence others. At issue as well are the distinctive notions of professionalism
11 attached to the profession of medicine and how they impact individuals and physician integrity;
12 and ethical differences among different promotional activities, e.g., whether the products or
13 services sold or promoted health- or non-health related and whether they are marketed to patients
14 or the general public.
15

16 The AMA *Code of Ethics* has existing relevant guidance: Opinions [9.6.4](#), “Sale of Health-Related
17 Products,” and [9.6.5](#), “Sale of Non-Health-Related Goods,” as well as Opinion [2.3.2](#),
18 “Professionalism in the Use of Social Media.” The Council will continue to review existing
19 guidance in contemplation of the relevant issues identified above and anticipates submitting a
20 report to the House of Delegates at a subsequent meeting.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 08-A-23

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

Presented by: Peter A. Schwartz, MD, Chair

1 At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a
2 detailed explanation of its judicial function. This undertaking was motivated in part by the
3 considerable attention professionalism has received in many areas of medicine, including the
4 concept of professional self-regulation.

5
6 CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove
7 a membership application or to take action against a member. The disciplinary process begins when
8 a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an
9 applicant or member is reported to the AMA. This information most often comes from statements
10 made in the membership application form, a report of disciplinary action taken by state licensing
11 authorities or other membership organizations, or a report of action taken by a government tribunal.

12
13 The Council rarely re-examines determinations of liability or sanctions imposed by other entities.
14 However, it also does not impose its own sanctions without first offering a hearing to the physician.
15 CEJA can impose the following sanctions: applicants can be accepted into membership without any
16 condition, placed under monitoring, or placed on probation. They also may be accepted, but be the
17 object of an admonishment, a reprimand, or censure. In some cases, their application can be
18 rejected. Existing members similarly may be placed under monitoring or on probation, and can be
19 admonished, reprimanded or censured. Additionally, their membership may be suspended or they
20 may be expelled. Updated rules for review of membership can be found at [https://www.ama-](https://www.ama-assn.org/governing-rules)
21 [assn.org/governing-rules](https://www.ama-assn.org/governing-rules).

22
23 Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial
24 activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities
25 during the most recent reporting period is presented.

APPENDIX

CEJA
*Judicial Function
 Statistics*

APRIL 1, 2022 – MARCH 31, 2023

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

Physicians Reviewed	<u>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</u>
9	No sanction or other type of action
2	Monitoring
14	Probation
1	Revocation
6	Suspension
2	Denied
1	Suspension lifted
4	Censure
12	Reprimand
4	Admonish

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

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 01-A-23

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

Presented by: Edmund Cabbabe, MD, Chair

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

4
5 (1) A report on the demographics of our AMA House of Delegates will be issued annually and
6 include information regarding age, gender, race/ethnicity, education, life stage, present
7 employment, and self-designated specialty. (2) As one means of encouraging greater awareness
8 and responsiveness to diversity, our AMA will prepare and distribute a state-by-state
9 demographic analysis of the House of Delegates, with comparisons to the physician population
10 and to our AMA physician membership every other year. (3) Future reports on the
11 demographic characteristics of the House of Delegates should, whenever possible, identify and
12 include information on successful initiatives and best practices to promote diversity within
13 state and specialty society delegations.
14

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

20
21 Guidelines for nominations for AMA elected offices include the following... (2) the Federation
22 (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in
23 electing Council and Board members), and the Board, the Speakers, and the President (in
24 appointing or nominating physicians for service on AMA Councils or in other leadership
25 positions) to consider the need to enhance and promote diversity...
26

27 Like previous reports, this document compares AMA leadership with the entire AMA membership
28 and with the overall U.S. physician population. Medical students are included in all references to
29 the total physician population, which is consistent with past practice. For the purposes of this
30 report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and
31 councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed
32 listing in Appendix A).
33

34 Additionally, this report includes information on successful initiatives and best practices to
35 promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.
36

37 DATA SOURCES

38

1 Lists of delegates and alternate delegates are maintained by the Office of House of Delegates
 2 (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this
 3 report reflect year-end 2022 delegation rosters. AMA council rosters as well as listings for the
 4 governing bodies of each of the sections and special groups were provided by the relevant AMA
 5 staff.

6
 7 Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile,
 8 which provides comprehensive demographic, medical education, and other information on all
 9 graduates of U.S. medical schools and international medical graduates (IMGs) who have
 10 undertaken residency training in the United States. Data on AMA members and the total physician
 11 population are taken from the year-end 2022 Masterfile after it is considered final.

12
 13 Some key considerations must be kept in mind regarding the information in this report. Members
 14 of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on
 15 Legislation who are not physicians or medical students are not included in any tables. Vacancies in
 16 delegation rosters mean the total number of delegates is fewer than the number allotted at the 2022
 17 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment.
 18 Race and ethnicity information, which is provided directly by physicians, is missing for
 19 approximately one-fifth of AMA members (20.0%) and the total U.S. physician population
 20 (20.4%), limiting the ability to draw firm conclusions.

21
 22 Readers are reminded that most AMA leadership groups considered herein designate seats for
 23 students and resident/fellow physicians. This affects some characteristics, particularly age, as well
 24 as the makeup of age-related groups, namely the student, resident, and young physician sections.
 25 To provide further clarity on this point, an additional table has been included in the appendix
 26 illustrating demographic characteristics and career stage breakdowns of AMA section governing
 27 councils.

28
 29 CHARACTERISTICS OF AMA LEADERSHIP

30
 31 Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians
 32 and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and
 33 downward-pointing arrows indicate an increase or decrease of at least two percentage points
 34 compared to CLRPD Report 1-A-21, “Demographic Characteristics of the House of Delegates and
 35 AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-21.
 36 Changes are not highlighted for the BOT due to the small number of Board members. Between
 37 year-end 2020 and year-end 2022, AMA membership increased by 3,061 members, a 1.1%
 38 increase.

- 39
 40 • Little change was observed in the age breakdown of AMA membership and leadership.
 41 The share of delegates in the 60-69 age group decreased by 3.9 percentage points since
 42 2020, but no age group saw a significant increase. Likewise, among councils and
 43 leadership of sections and special groups, two age groups (under age 40 and age 50-59)
 44 saw increased representation, while two others (40-49 and 60-69) saw their percentages
 45 decrease, but these changes seem more attributable to fluctuation than any specific trend.
 46
 47 • A continued increase in female representation among AMA delegates and alternate
 48 delegates was observed, as females in 2022 made up 34.3% of delegates (up from 30.7% in
 49 2020) and 43.7% of alternate delegates (38.3% in 2020). Over the past decade, the number
 50 of female delegates and alternate delegates has increased steadily; in 2012, 20.2% of
 51 delegates and 21.5% of alternate delegates identified as female.

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- The percentage of white delegates and alternate delegates decreased by 3.5 percentage points and 4.4 percentage points, respectively.
- The percentage of international medical graduate (IMG) alternate delegates increased by 2.7 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2022

	Delegates ¹	Alternate Delegates ²	Board of Trustees ²	Councils and Leadership of Sections and Special Groups ³	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Mean age ⁴	56.7	50.1	54.4	51.1	47.1	52.9
Age Distribution						
Under age 40	15.4%	30.4%	10.0%	30.5%↑	51.4%	29.4%
40-49 years	15.0%	17.7%	20.0%	13.8%↓	11.2%	17.6%
50-59 years	20.0%	19.7%	30.0%	21.6%↑	9.8%	16.4%
60-69 years	28.3%↓	22.3%	30.0%	19.2%↓	9.6%	16.2%
70 or more	21.3%	10.0%	10.0%	15.0%	18.0%	20.4%
Gender						
Male	65.7%↓	55.8%↓	60.0%	50.9%	60.0%	62.7%
Female	34.3%↑	43.7%↑	40.0%	49.1%	39.5%	36.6%
Unknown	0.0%	0.5%	0.0%	0.0%	0.6%	0.8%
Race/Ethnicity						
White non-Hispanic	65.8%↓	57.3%↓	45.0%	56.9%	48.9%	49.7%
Black non-Hispanic	5.5%	4.9%	15.0%	6.6%	4.9%	4.3%
Hispanic	3.0%	4.4%	5.0%	3.0%	4.5%	4.6%
Asian/Asian American	12.7%	15.9%	20.0%	18.6%	15.4%	15.8%
Native American	0.3%	0.3%	0.0%	0.0%	0.2%	0.2%
Other ⁵	2.6%	5.9%↑	0.0%	7.2%↑	6.2%↑	5.0%↑
Unknown	10.1%	11.5%	15.0%	7.8%	20.0%	20.4%
Education						
US or Canada	92.1%	89.5%↓	100.0%	88.0%	81.9%	77.7%
IMG	7.9%	10.5%↑	0.0%	12.0%	18.1%	22.3%

¹ Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

² Numbers do not include the public member of the Board of Trustees, who is not a physician.

³ Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.

⁴ Age as of December 31. Mean age is the arithmetic average.

⁵ Includes other self-reported racial and ethnic groups.

- 1 Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.
 2 • No significant changes were observed to the life stage, employment, and specialty
 3 characteristics of delegates to the HOD. Among alternate delegates, decreases were
 4 observed among established physicians (from 49.7% in 2020 to 44.0% in 2022), employees
 5 of the U.S. government (4.1% in 2020, 2.1% in 2022) and internal medicine specialists
 6 (19.2% in 2020, 15.1% in 2022). The percentage of senior physician alternate delegates
 7 increased from 19.4% to 22.5% since 2020.
 8
 9 • Among CSSG, increases were observed among young physicians (9.6% in 2020, 13.2% in
 10 2022), employees of non-government hospitals (4.2% in 2020, 6.6% in 2022) and internal
 11 medicine specialists (18.7% in 2020, 22.2% in 2022). Decreases were observed among
 12 senior physicians (28.9% in 2020, 24.6% in 2022), employees of state or local government
 13 hospitals (10.8% in 2020, 7.2% in 2022) and OB/GYN specialists (13.3% in 2020, 9.6% in
 14 2022).

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student ⁶	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Resident ⁶	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Young (Under age 40 or first eight years of practice) [^]	7.4%	14.3%	0.0%	13.2%↑	9.9%	15.4%
Established (Age 40-64) [^]	45.1%	44.0%↓	65.0%	41.3%	21.7%	37.9%
Senior (Age 65 or more) [^]	36.9%	22.5%↑	25.0%	24.6%↓	22.8%	28.6%
Present Employment						
Self-employed solo practice	12.1%	8.4%	15.0%	10.8%	6.2%	7.6%
Two physician practice	1.7%	2.1%	5.0%	1.2%	1.3%	1.8%
Group practice	39.8%	38.6%	45.0%	34.7%	24.0%	39.7%
Non-government hospital	7.7%	7.2%	10.0%	6.6%↑	3.0%	4.1%
State or local government hospital	10.3%	9.7%	5.0%	7.2%↓	3.6%	6.0%
HMO	1.1%	0.5%	0.0%	1.2%	0.2%	0.2%
Medical School	3.9%	2.8%	10.0%	3.6%	0.9%	1.4%

⁶ Students and residents are so categorized without regard to age.

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

U.S. Government	3.0%	2.1%↓	0.0%	3.6%	0.8%	1.6%
Locum Tenens	0.3%	0.3%	0.0%	1.2%	0.1%	0.2%
Retired/Inactive	7.7%	4.6%	0.0%	6.6%	11.4%	12.6%
Resident/Intern/Fellow	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Other/Unknown	1.8%	4.6%	0.0%	2.4%	2.7%	7.0%
Self-designated specialty⁷						
Family Medicine	11.0%	11.0%	5.0%	10.8%	8.8%	11.3%
Internal Medicine	21.8%	15.1%↓	20.0%	22.2%↑	20.6%	22.8%
Surgery	22.1%	17.4%	30.0%	15.6%	13.4%	13.3%
Pediatrics	3.5%	5.4%	0.0%	7.2%	5.3%	8.7%
OB/GYN	5.9%	7.9%	15.0%	9.6%↓	4.9%	4.5%
Radiology	5.8%	5.1%	5.0%	2.4%	3.6%	4.4%
Psychiatry	3.8%	5.6%	0.0%	4.8%	4.4%	5.2%
Anesthesiology	3.8%	3.1%	5.0%	2.4%	3.9%	4.9%
Pathology	2.0%	3.8%	0.0%	0.0%	1.7%	2.2%
Other specialty	15.6%	15.1%	15.0%	15.6%	13.9%	14.7%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%

1 For further data, including information on state medical associations and national medical specialty
 2 societies, raw counts of the above tables, and detailed state and specialty society data, please see
 3 the appendices.

4
 5 **PROMOTING DIVERSITY AMONG DELEGATIONS**

6
 7 Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on
 8 initiatives they have instituted to encourage diversity among their delegations, and the outcomes of
 9 these initiatives.

- 10
 11 • Convening groups with a focus on diversity: several societies mentioned convening task
 12 forces, councils and/or committees with the goal of evaluating and/or increasing diversity
 13 among their organization, including their delegations and other leadership positions.
 14 Societies that have implemented these types of groups reported a number of beneficial
 15 outcomes including advising the society on internal and external action, developing
 16 educational programming and online content, writing grants, and increasing diversity at
 17 society meetings.
- 18
 19 • Intentional recruitment: societies mentioned making a conscious effort to recruit diverse
 20 candidates from across their organizations and ready them for larger leadership
 21 opportunities. Additionally, some societies reported making conscious outreach efforts to
 22 medical students, including those from historically black colleges and universities, with the
 23 goal of increasing diversity within their respective societies, and in the case of specialties,
 24 among the specialty itself.
- 25
 26 • Initiatives and summits: societies mentioned instituting a variety of initiatives focused on
 27 issues related to equity, diversity, and inclusion. These included convening members with
 28 interest in addressing lifestyle-related chronic disease health disparities, training and

⁷ See Appendix B for a listing of specialty classifications.

1 certification scholarships for physicians who are representative of and delivering care to
2 underserved communities, leadership summits to prepare young members for future
3 leadership roles, and podcasts to discuss issues related to health and wellness through a
4 DEI lens.

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2022

	Delegates ²	Alternate Delegates ²	Board of Trustees ³	Councils and Leadership of Sections and Special Groups ⁴	AMA Members	All Physicians and Medical Students
Mean age ⁵	56.7	50.1	54.4	51.1	47.1	52.9
Count	661	391	20	167	274,716	1,455,177
Age distribution						
Under age 40	102	119	2	51	141,319	428,442
40-49 years	99	69	4	23	30,766	255,897
50-59 years	132	77	6	36	26,892	238,054
60-69 years	187	87	6	32	26,436	236,073
70 or more	141	39	2	25	49,303	296,711
Gender						
Male	434	218	12	85	164,789	911,708
Female	227	171	8	82	108,362	532,338
Unknown	-	2	-	-	1,565	11,131
Race/ethnicity						
White non-Hispanic	435	224	9	95	134,244	723,379
Black non-Hispanic	36	19	3	11	13,379	63,150
Hispanic	20	17	1	5	12,234	67,553
Asian/Asian American	84	62	4	31	42,310	229,363
Native American	2	1	-	-	470	2,546
Other ⁶	17	23	-	12	17,096	72,773
Unknown	67	45	3	13	54,983	296,413
Education						
US or Canada	609	350	20	147	224,961	1,130,279
IMG	52	41	0	20	49,755	324,898

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

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

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

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

⁶ Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty¹ of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student ⁸	32	41	1	16	53,542	116,060
Resident ¹	38	34	1	19	71,984	147,487
Young (Under age 40 or first eight years of practice) ^	49	56	-	22	27,193	224,043
Established (Age 40-64) ^	298	172	13	69	59,495	551,790
Senior (Age 65 or more) ^	244	88	5	41	62,502	415,797
Present Employment						
Self-employed solo practice	80	33	3	18	16,927	110,247
Two physician practice	11	8	1	2	3,631	25,396
Group practice	263	151	9	58	66,043	577,636
Non-government hospital	51	28	2	11	8,164	59,397
State or local government hospital	68	38	1	12	9,935	86,655
HMO	7	2	0	2	650	2,250
Medical School	26	11	2	6	2,450	20,076
U.S. Government	20	8	0	6	2,279	22,607
Locum Tenens	2	1	0	2	365	2,589
Retired/Inactive	51	18	0	11	31,308	183,396
Resident/Intern/Fellow	38	34	1	19	71,984	147,487
Student	32	41	1	16	53,542	116,060
Other/Unknown	12	18	0	4	7,438	101,381
Self-designated specialty						
Family Medicine	73	43	1	18	24,050	164,511
Internal Medicine	144	59	4	37	56,630	331,181
Surgery	146	68	6	26	36,839	193,274
Pediatrics	23	21	0	12	14,681	126,906
OB/GYN	39	31	3	16	13,549	65,941
Radiology	38	20	1	4	9,809	64,423

⁸ Students and residents are so categorized without regard to age.[^] Reflects section/group definition of its membership.

Psychiatry	25	22	0	8	12,014	75,523
Anesthesiology	25	12	1	4	10,798	71,625
Pathology	13	15	0	0	4,748	31,777
Other specialty	103	59	3	26	38,056	213,956
Student	32	41	1	16	53,542	116,060

See Appendix B for a listing of specialty classifications.

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2022

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other ⁹
Mean age ¹⁰	51.8	42.0	45.2	41.4	40.4	43.1
Count	134,244	13,379	12,234	42,310	470	72,079
Age distribution						
Under age 40	42.0%	55.6%	49.7%	58.6%	52.1%	64.3%
40-49 years	10.4%	15.6%	16.2%	15.4%	22.3%	8.5%
50-59 years	10.8%	12.9%	12.8%	11.9%	20.4%	5.4%
60-69 years	12.4%	8.9%	9.4%	5.5%	4.0%	7.1%
70 or more	24.4%	6.9%	11.9%	8.6%	1.1%	14.6%
Gender						
Male	65.5%	44.3%	58.9%	53.3%	52.1%	56.9%
Female	34.5%	55.7%	41.1%	46.7%	47.9%	41.1%
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.1%
Life Stage						
Student ¹¹	15.5%	24.1%	20.4%	21.5%	21.7%	24.6%
Resident ⁴	19.9%	25.6%	26.3%	27.8%	27.2%	37.1%
Young (Under age 40 or first eight years of practice) [^]	9.8%	12.9%	5.2%	14.1%	10.0%	7.8%
Established (Age 40-64) [^]	24.0%	26.8%	32.0%	25.6%	39.2%	12.2%
Senior (Age 65 or more) [^]	30.8%	10.8%	16.1%	11.0%	1.9%	18.2%
Education						
US or Canada	92.2%	85.6%	73.5%	67.8%	93.8%	71.6%
IMG	7.8%	14.4%	26.5%	32.2%	6.2%	28.4%

⁹ Includes other self-reported racial and ethnic groups.

¹⁰ Age as of December 31. Mean age is the arithmetic average.

¹¹ Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

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

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2022

	APS	IPPS	IMGS	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age	62.4	57.7	42.6	27.3	45.9	65.4	54.9	30.9	71.9	46.3	37.1
Life Stage											
Student	-	-	-	9	-	-	-	-	-	-	-
Resident	-	-	-	-	2	-	-	8	-	1	-
Young (Under age 40 or first eight years of practice) ^	-	-	6	-	1	-	2	-	-	2	7
Established (Age 40- 64)^	5	6	1	-	3	3	3	-	1	3	-
Senior (Age 65 or over)^	3	1	-	-	1	4	2	-	6	1	-
Gender											
Male	4	6	3	4	2	4	3	4	5	-	4
Female	4	1	4	5	5	3	4	4	2	7	3
Unknown	-	-	-	-	-	-	-	-	-	-	-
Race/ethnicity											
White non- Hispanic	4	5	3	4	1	5	5	3	5	3	6
Black non- Hispanic	1	-	-	1	3	-	-	-	-	1	-
Hispanic	1	-	-	1	2	1	-	-	-	-	-
Asian/Asian American	1	1	2	2	-	1	1	1	2	2	-
Native American	-	-	-	-	-	-	-	-	-	-	-
Other ¹	-	-	2	1	1	-	-	3	-	-	1
Unknown	1	1	-	-	-	-	1	1	-	1	-
Education											
US or Canada	7	5	-	9	7	6	6	8	6	7	7
IMG	1	2	7	-	-	1	1	-	1	-	-

^ Reflects section/group definition of its membership.

¹ Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2022

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =274,716)	47.1	39.5%	18.1%	26.2%
Specialty Society Delegates and Alternates (n =418)	55.3	38.5%	7.9%	2.9%
Family Medicine Delegations (n =30)	52.9	50.0%	6.7%	3.3%
Internal Medicine Delegations (n =92)	57.1	38.0%	13.0%	4.4%
Surgery Delegations (n = 90)	56.0	23.3%	7.8%	2.2%
Pediatrics Delegations (n = 12)	52.3	83.3%	0.0%	0.0%
OB/GYN Delegations (n = 28)	54.8	71.4%	7.1%	3.6%
Radiology Delegations (n = 34)	56.1	35.3%	5.9%	0.0%
Psychiatry Delegations (n =22)	54.1	45.5%	9.1%	0.0%
Anesthesiology Delegations (n =13)	56.2	15.4%	0.0%	0.0%
Pathology Delegations (n =20)	54.5	30.0%	5.0%	0.0%
Other specialty Delegations (n =77)	53.7	39.0%	6.5%	5.2%

Table 8. Mean Age of AMA Members and Delegations by State, December 2022

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	3,073	51.9	8	58.6
Alaska	349	56.2	2	†
Arizona	4,632	54.7	10	61.1
Arkansas	1,948	52.3	5	63.4
California	31,743	55.0	62	54.3
Colorado	5,486	53.0	8	56.1
Connecticut	3,072	53.4	8	62.8
Delaware	835	55.6	2	†
District of Columbia	1,957	45.6	3	†
Florida	16,122	55.9	30	59.1
Georgia	5,901	52.6	11	59.3
Guam	20	59.3		
Hawaii	997	56.8	3	†
Idaho	774	55.9	2	†
Illinois	11,329	51.9	23	63.3
Indiana	4,646	52.5	9	65.2
Iowa	3,162	52.6	6	54.0
Kansas	2,251	52.5	7	63.1
Kentucky	3,999	51.5	8	62.5
Louisiana	5,906	50.0	7	52.1
Maine	1,144	55.4	2	†
Maryland	5,084	54.5	10	59.1
Massachusetts	12,481	51.2	19	57.0
Michigan	13,192	50.5	26	57.7
Minnesota	4,681	52.8	10	59.2
Mississippi	2,728	51.4	6	56.5
Missouri	4,900	49.3	9	59.9
Montana	684	57.1	2	†
Nebraska	1,654	49.0	4	47.8
Nevada	1,683	54.1	4	71.8
New Hampshire	893	54.9	3	†
New Jersey	7,603	54.6	12	67.1
New Mexico	1,187	55.7	4	55.0
New York	19,600	52.4	22	56.8
North Carolina	5,259	51.9	6	61.2
North Dakota	722	51.0	2	†
Ohio	10,214	50.7	18	51.3
Oklahoma	3,314	52.0	7	63.1
Oregon	3,145	54.9	5	58.4
Other	793	67.9	1	†
Pennsylvania	11,663	51.7	23	59.5
Puerto Rico	1,440	55.8	1	†
Rhode Island	1,030	50.4	5	61.8
South Carolina	3,683	51.7	10	64.3
South Dakota	975	52.2	5	63.6

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

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Tennessee	5,422	52.0	11	62.4
Texas	19,908	50.9	35	59.9
Utah	1,799	50.5	4	52.5
Vermont	460	53.0	1	†
Virgin Islands	29	65.2		
Virginia	7,000	53.0	10	60.4
Washington	5,445	54.8	10	49.7
West Virginia	1,872	50.1		
Wisconsin	4,621	52.8	7	62.0
Wyoming	206	59.1	2	†
TOTAL	274,716	53.1	510	59.1

Table 9. Women and International Medical Graduates on State Association Delegations, December 2022

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,073	8	34.0%	3	12.6%	-
Alaska	349	2	40.4%	1	10.0%	-
Arizona	4,632	10	36.0%	4	15.0%	-
Arkansas	1,948	5	37.2%	1	13.1%	1
California	31,743	62	41.0%	20	18.2%	3
Colorado	5,486	8	43.8%	5	5.9%	-
Connecticut	3,072	8	40.1%	4	21.2%	2
Delaware	835	2	34.6%	2	28.9%	-
District of Columbia	1,957	3	51.3%	-	12.1%	-
Florida	16,122	30	35.2%	9	29.4%	4
Georgia	5,901	11	40.8%	3	17.9%	1
Guam	20	-	15.0%	-	60.0%	-
Hawaii	997	3	34.0%	1	12.7%	-
Idaho	774	2	29.5%	1	5.8%	-
Illinois	11,329	23	39.6%	8	21.6%	6
Indiana	4,646	9	36.4%	2	16.0%	2
Iowa	3,162	6	36.1%	3	16.1%	-
Kansas	2,251	7	34.3%	2	12.8%	1
Kentucky	3,999	8	37.9%	1	14.3%	-
Louisiana	5,906	7	41.5%	-	15.5%	1
Maine	1,144	2	44.8%	1	8.4%	-
Maryland	5,084	10	43.0%	5	23.6%	3
Massachusetts	12,481	19	48.3%	7	15.0%	1
Michigan	13,192	26	38.6%	8	22.5%	4
Minnesota	4,681	10	38.9%	5	14.8%	-
Mississippi	2,728	6	33.7%	2	10.5%	1
Missouri	4,900	9	39.6%	3	10.4%	2
Montana	684	2	42.3%	1	4.5%	-
Nebraska	1,654	4	39.4%	1	8.0%	-
Nevada	1,683	4	35.8%	1	19.4%	1
New Hampshire	893	3	37.1%	1	16.9%	-
New Jersey	7,603	12	37.1%	4	29.2%	2
New Mexico	1,187	4	38.6%	2	14.2%	-
New York	19,600	22	40.7%	3	27.2%	2
North Carolina	5,259	6	36.1%	4	13.4%	-
North Dakota	722	2	38.6%	-	15.2%	1
Ohio	10,214	18	39.7%	6	15.8%	1
Oklahoma	3,314	7	36.6%	2	11.1%	-
Oregon	3,145	5	41.9%	1	8.7%	-
Other	793	1	16.3%	1	56.0%	-
Pennsylvania	11,663	23	37.1%	1	15.5%	4
Puerto Rico	1,440	1	43.3%	-	20.1%	-
Rhode Island	1,030	5	43.7%	2	16.3%	-

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	3,683	10	39.6%	1	8.9%	-
South Dakota	975	5	37.2%	1	10.1%	1
Tennessee	5,422	11	38.8%	3	10.3%	2
Texas	19,908	35	40.8%	11	17.6%	4
Utah	1,799	4	26.6%	2	5.5%	-
Vermont	460	1	39.8%	-	9.3%	-
Virgin Islands	29	-	27.6%	-	31.0%	-
Virginia	7,000	10	41.5%	5	17.4%	1
Washington	5,445	10	39.6%	5	15.1%	1
West Virginia	1,872	-	36.7%	-	22.8%	-
Wisconsin	4,621	7	36.8%	3	16.7%	1
Wyoming	206	2	28.2%	-	11.2%	-
TOTAL	274,716	510	39.4%	162	18.1%	53

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates ¹	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates ²
Alabama	3,073	8	501	1	1	879	1	1
Alaska	349	2	5	-	-	33	-	-
Arizona	4,632	9	833	1	1	1,505	2	-
Arkansas	1,948	5	570	1	1	376	-	-
California	31,743	61	3,416	7	5	6,642	7	2
Colorado	5,486	8	1,651	1	1	691	-	-
Connecticut	3,072	6	689	3	3	665	-	-
Delaware	835	2	22	-	-	107	-	-
District of Columbia	1,957	2	678	-	-	526	2	2
Florida	16,122	30	2,598	3	3	4,460	-	-
Georgia	5,901	11	1,058	2	2	1,149	-	-
Guam	20	-	-	-	-	2	-	-
Hawaii	997	3	156	-	-	118	-	-
Idaho	774	2	112	-	-	66	-	-
Illinois	11,329	23	2,727	2	1	2,522	5	1
Indiana	4,646	9	626	3	3	1,644	-	-
Iowa	3,162	6	386	-	-	769	-	-
Kansas	2,251	7	537	-	-	409	-	-
Kentucky	3,999	8	917	1	1	846	1	1
Louisiana	5,906	7	1,107	2	2	2,068	2	-
Maine	1,144	2	382	-	-	201	-	-
Maryland	5,084	10	610	1	1	935	1	-
Massachusetts	12,481	19	3,396	6	5	5,344	5	2
Michigan	13,192	25	1,847	2	1	5,085	1	-
Minnesota	4,681	10	634	1	1	1,428	-	-

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates ¹	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates ²
Mississippi	2,728	6	626	1	1	740	1	1
Missouri	4,900	8	1,523	1	1	1,286	1	1
Montana	684	2	273	-	-	38	-	-
Nebraska	1,654	3	644	1	1	234	1	1
Nevada	1,683	4	328	-	-	491	2	2
New Hampshire	893	3	140	-	-	166	-	-
New Jersey	7,603	12	1,231	2	2	1,561	-	-
New Mexico	1,187	4	231	-	-	170	-	-
New York	19,600	18	4,029	4	3	6,231	-	-
North Carolina	5,259	6	815	-	-	1,288	1	-
North Dakota	722	2	340	-	-	84	-	-
Ohio	10,214	17	2,792	4	3	2,617	2	1
Oklahoma	3,314	5	1,030	-	-	849	-	-
Oregon	3,145	5	311	-	-	464	-	-
Other	793	1	22	-	-	66	-	-
Pennsylvania	11,663	22	2,210	3	2	3,007	2	-
Puerto Rico	1,440	1	578	-	-	280	-	-
Rhode Island	1,030	5	265	-	-	262	-	-
South Carolina	3,683	10	1,114	2	2	827	-	-
South Dakota	975	5	350	-	-	130	-	-
Tennessee	5,422	11	1,324	-	-	1,632	1	-
Texas	19,908	32	4,346	5	4	6,497	5	4
Utah	1,799	3	337	-	-	325	-	-
Vermont	460	1	98	-	-	97	-	-
Virgin Islands	29	-	-	-	-	-	-	-
Virginia	7,000	10	1,642	2	2	1,423	1	-
Washington	5,445	9	440	-	-	676	-	-

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates ¹	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates ²
West Virginia	1,872	-	371	-	-	774	-	-
Wisconsin	4,621	6	671	1	1	1,273	1	1
Wyoming	206	2	3	-	-	18	-	-
TOTAL	274,716	488	53,542	63	54	71,976	45	20

¹ The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

² Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Family Physicians, American Academy of Neurology, American Academy of Pediatrics, American Association of Neurological Surgeons, American Association of Public Health Physicians, American College of Emergency Physicians, American Geriatrics Society, American Psychiatric Association, American Urological Association, Infectious Diseases Society of America, and Society of Critical Care Medicine. This table reflects information available as of January 31, 2023, and is subject to change. Information on alternate delegates was not available.

Figure 1. Demographic Characteristics of AMA Members, 2002-2022

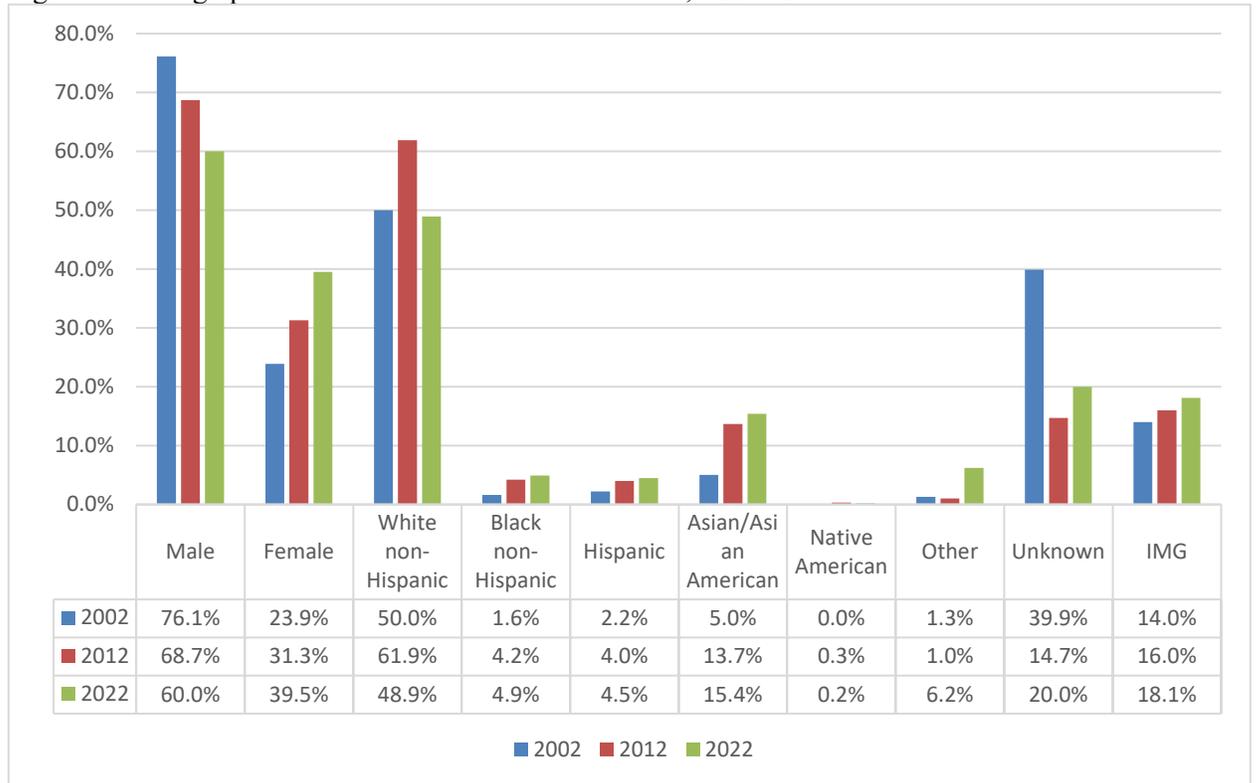


Figure 2. Self-Identified Race/Ethnicity of Delegates and Alternate Delegates, 2002-2022

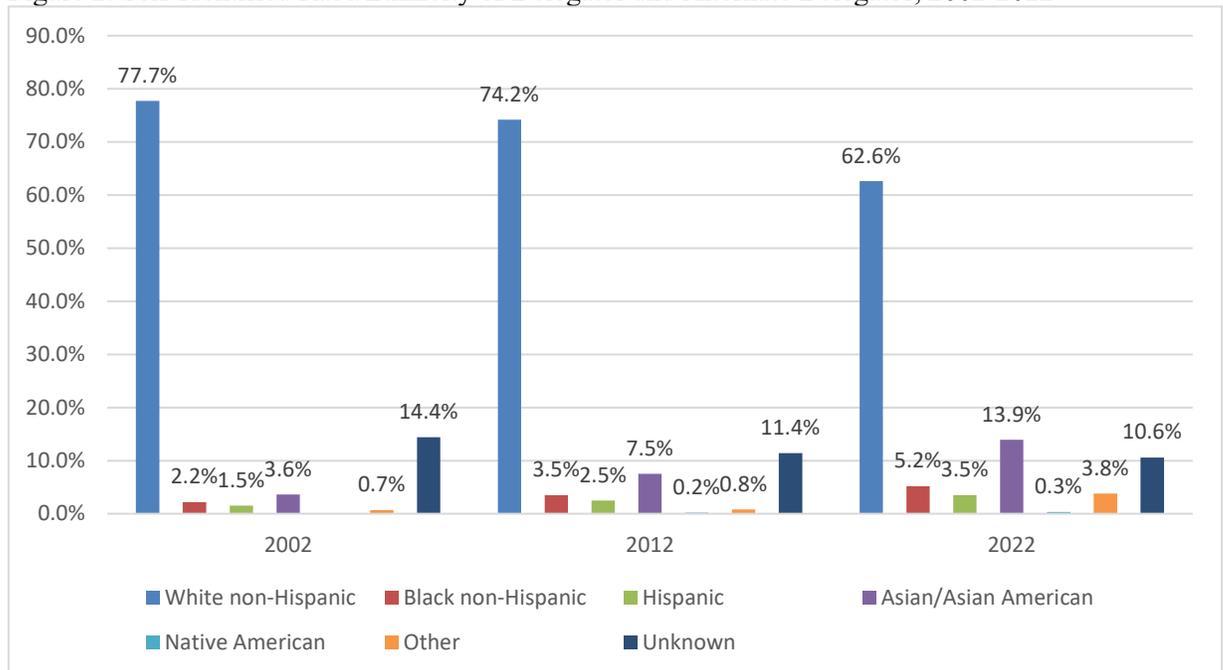


Figure 3. Self-Identified Race/Ethnicity of AMA Board of Trustees, 2002-2022

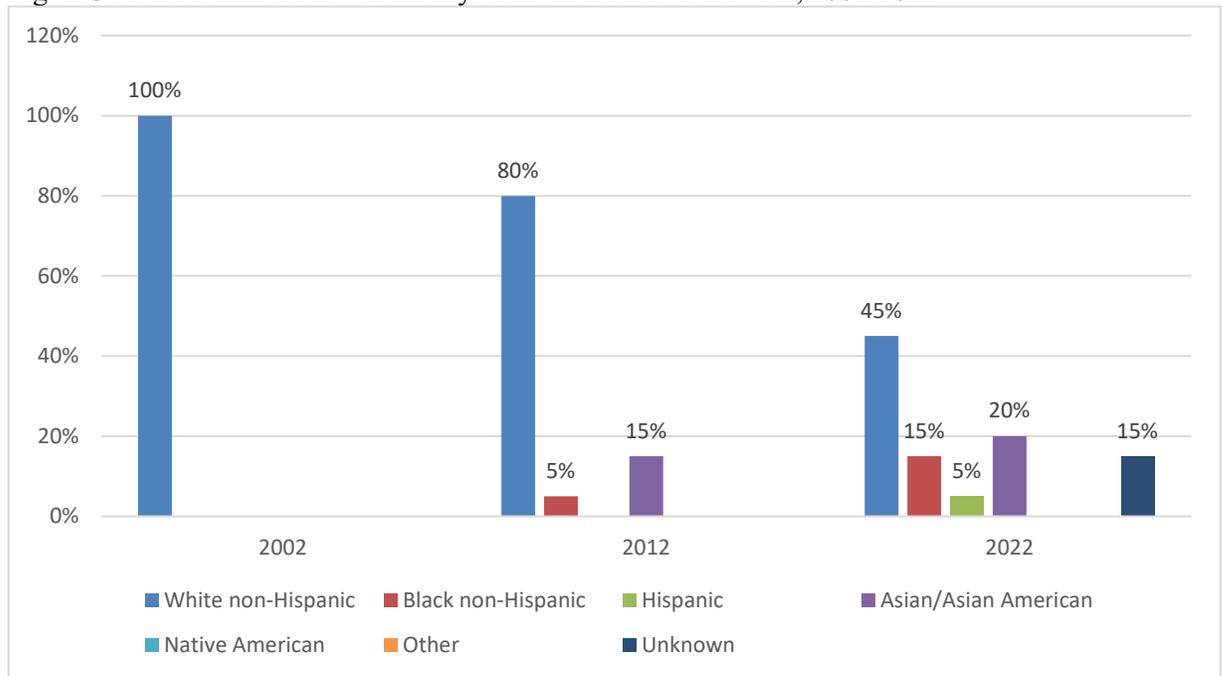


Figure 4. Self-Identified Race/Ethnicity of Councils and Section and Special Group Leadership, 2012-2022

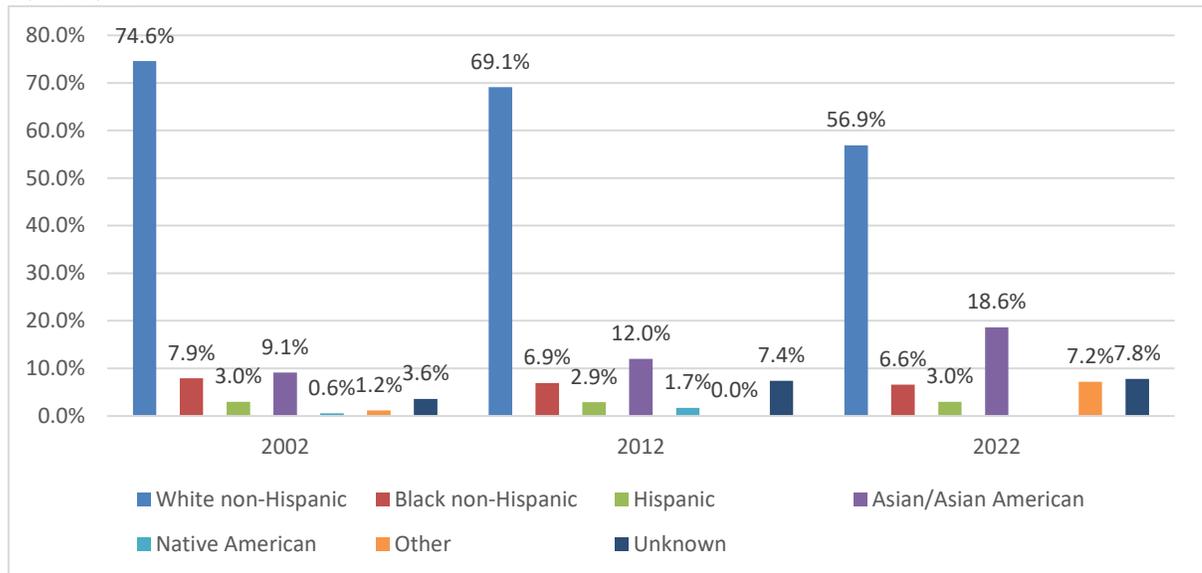


Figure 5. Percentage of Female AMA Leadership, 2002-2022

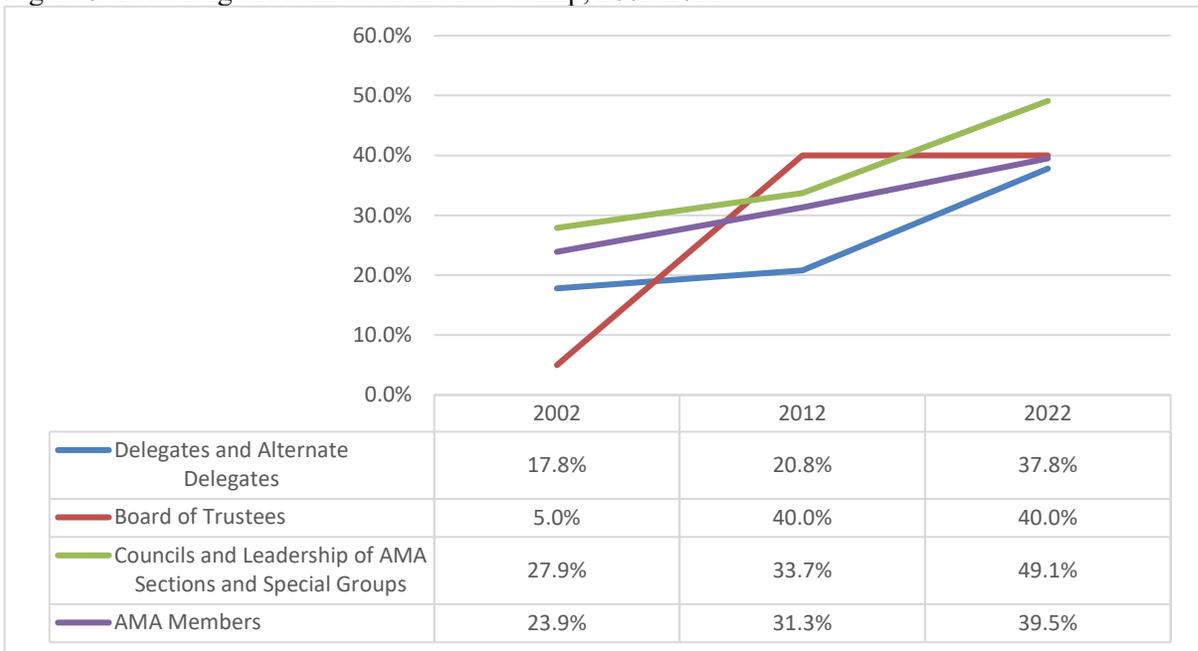
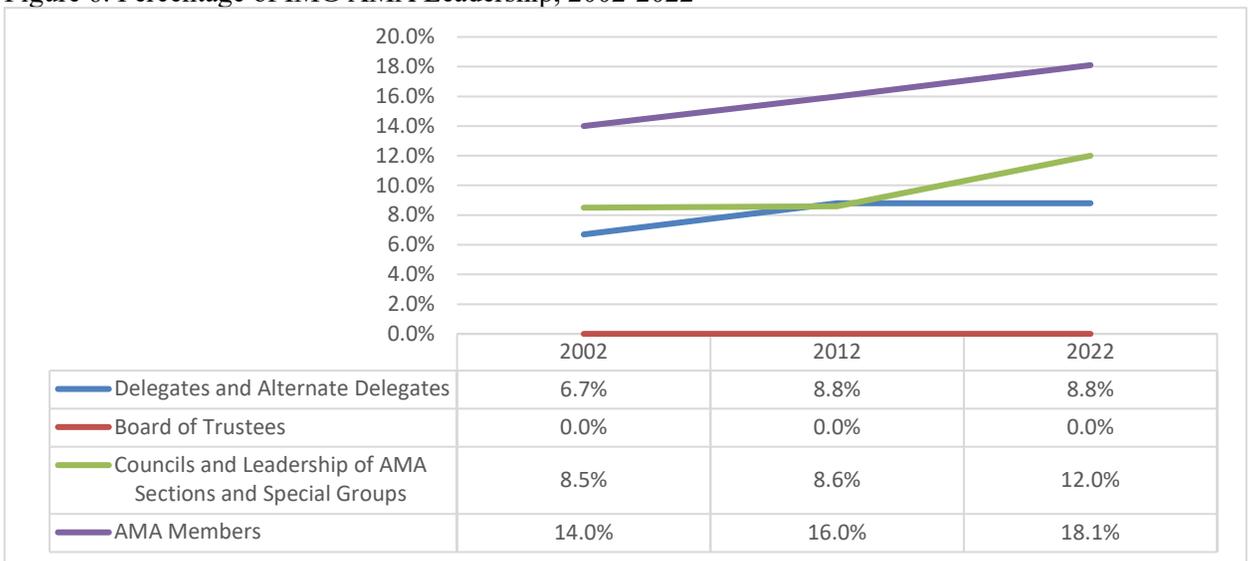


Figure 6. Percentage of IMG AMA Leadership, 2002-2022



APPENDIX B

Specialty classification using physicians' self-designated specialties

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

American Medical Association Councils, Sections and Special Groups

COUNCILS

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

SECTIONS

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

- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

APPENDIX B

Specialty classification using physicians' self-designated specialties

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

REPORT 02 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
(A-23) A Primer on the Medical Supply Chain

EXECUTIVE SUMMARY

The medical supply chain is an extensive network of systems, components, and processes that collectively work to ensure medicines and other health care supplies are manufactured, distributed, and provided to patients. In the broadest sense, a supply chain includes all activities related to manufacturing, the extraction of raw materials, processing, warehousing, and transportation. Hence, for large multinational companies that manufacture complex products, supply chains are highly complex socioeconomic systems. To strengthen and stabilize the medical supply chain, it is important to understand the various aspects of the medical supply chain, to identify the challenges that resulted in supply chain disruptions during the pandemic, and to consider several strategies to mitigate medical supply chain disruptions for the future.

Over decades, the medical supply chain has assembled substantial global networks; however, the pandemic has exposed structural weaknesses and cracks within these networks. Many medical supply distributors and health systems had adopted a “just-in-time” approach to supplies, by which they stocked only what they immediately needed and trusted supply chains to deliver other items quickly. At the same time, much of America’s manufacturing capacity shifted abroad, where products could be made inexpensively with low labor and energy costs. While American manufacturing’s share of overall output remained constant, its labor share declined as firms automated production lines and relied upon emerging technologies. That production and distribution system worked as planned until difficulties in the global supply chain disrupted those practices and created problems in supply, safety, and security. Today’s problems include a wide array of medical supply and equipment shortages that can be traced to component scarcities, factory closures, backlogged ports, and transportation glitches.

The disruptions caused by the “just-in-time” approach have led to calls for greater domestic manufacturing capability through onshoring or reshoring (bringing production back to the United States) or nearshoring (bringing production back to friendly countries not far from the U.S., such as Canada and Mexico). One of the key areas affected by the pandemic was the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S. market—72% of the medical supplies and APIs for making drugs found in the United States have resulted from outsourcing to other countries. While locally sourced API production will likely become an increasingly important part of government policy and pharmaceutical company commercial strategy, diversifying supply chains is expensive, and the cost of reconfiguring them will fall on consumers or governments.

Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical conflict, economic conditions, and quality-related issues at production sites. These factors can impact daily health care, as well as the profitability of manufacturing companies. In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring needed supplies, including shortages of key items and significant price increases.

Most experts agree that stakeholders must come together to develop consistent, meaningful metrics that reflect a sophisticated approach to managing and preventing shortages that pose risks to health care systems and patients. There are several automated technologies available that health care systems can use to quickly access data and projections: cloud-based, radio-frequency identification

(RFID) technology allows for real-time tracking that prevents shortages while enabling health care professionals to view their inventory quickly and accurately; internet-connected medical devices and equipment enable different systems in health care organizations to speak to one another and ensure information is updated across departments, rather than being held up in siloes; and analytics platforms, powered by artificial intelligence (AI), can be embedded in an electronic health record (EHR) to allow users to access benchmarking data so they can analyze their overall performance.

In a recent McKinsey survey of U.S. health system and supply chain executives, three themes emerged as critical to a high-performing medical supply chain function:

- *Engage front-line physicians in supply decisions,*
- *Jointly set goals across facilities and functions, and*
- *Invest in accurate, actionable data and analytics.*

While the pandemic caused major disruptions in health care with severe consequences, it also spurred medical and technological innovations. Telemedicine has become common, medical professionals have urged adoption of new models of care, shifting from cost-efficiency to long-term planning, and public-private partnerships have been formed to deal with current and future crises. Patient care has historically been limited to a person's ability to arrive at a hospital or care facility and restricted by the supply chain's capacity to swiftly provide the correct product for that patient's individual need. Technology has recently enhanced treatment products to allow patients to receive care outside of a traditional care facility. The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be provided while saving manufacturing costs.

Artificial Intelligence (AI) and predictive analytics—while being used nominally right now by physicians and health care organizations—can, should, and will be used to ensure the right items, from the right sources, at the right prices for the right outcomes are ordered at the right times and in the right quantities to prevent shortages and price gouging. This will help to ensure financial stability of medical practices and health care organizations while mitigating patient risk. Although technology is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear to address weaknesses may only partially fix the issues. Comprehensive solutions that position technology as a component alongside people and processes can help make the medical supply chain more resilient. Several large health care organizations have developed partnerships with shared goals and vision between physicians and hospital administrations. What is necessary to further these efforts is an investment in evidence tools and the creation of a physician role in the supply chain, which is becoming more common.

The future of the medical supply chain entails transparent communication of supply chain issues and patient needs between suppliers and health care professionals who can work together to create methods that enhance situational awareness. The medical supply chain can gain physician trust by communicating regularly and providing insight into the inner workings of logistics. Physicians can articulate needs, and medical supply chain professionals can provide information about the prices of products and transportation, outcomes, and alternative options for their products. Addressing these issues can improve the relationship between the supply chain, physicians, and health care organizations. Effective supply chain performance directly links to patient outcomes and clinical safety, influencing much more than personal protective equipment (PPE).

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 02-A-23

Subject: A Primer on the Medical Supply Chain

Presented by: Edmond Cabbabe, MD, Chair

1 The critical medical shortages that resulted from COVID-19 hampered the pandemic response and
2 cascaded into defaults of other aspects of U.S. health care delivery. This informational report was
3 developed to provide members of the House of Delegates (HOD) with some history of medical
4 supply chain shortages, the structure of the medical supply chain, globalization of the U.S. medical
5 supply chain, causes and consequences of failures, U.S. governmental actions to mitigate issues,
6 and onshoring and nearshoring strategies for the U.S. medical supply chain. It also identifies
7 opportunities for physicians and health systems to improve medical supply chain resilience and
8 performance.

9
10 BRIEF HISTORY OF U.S. MEDICAL SUPPLY CHAIN SHORTAGES11
12 Shortages of medical supplies in the United States due to supply chain issues are not new.

- 13
- 14 • During War II, the supply of quinine that was primarily sourced in the Japanese-occupied
15 East Indies, was cut off. The United States suddenly found itself facing malaria across the
16 globe without sufficient treatment, which resulted in major hospitalizations from malarial
17 infections throughout different battles and theaters.¹
- 18 • In September 2017, Hurricane Maria devastated the territory of Puerto Rico—producer of
19 50% of America’s supply of intravenous saline—catapulting hospitals nationwide into a
20 shortage.²
- 21 • In late 2019, SARS-CoV-2 emerged from China and rapidly evolved into a pandemic,
22 resulting in disrupted production and export of medications and personal protective
23 equipment (PPE) around the world.
- 24

25 The critical medical shortages that resulted from COVID-19 hampered the pandemic response and
26 cascaded into defaults of other aspects of U.S. health care delivery. What differentiates COVID-19
27 from prior supply chain disruptions is the level of uncertainty and the length of the disruption, as
28 well as its simultaneous global impact. Additionally, unlike most other disruptions, COVID-19 has
29 affected not only the supply of, but also the demand for products and services.

30
31 MEDICAL SUPPLY CHAIN STRUCTURE

32

33 The medical supply chain is an extensive network of systems, components, and processes that
34 collectively work to ensure medicines and other health care supplies are manufactured, distributed,
35 and provided to patients. In the broadest sense, a supply chain includes all activities related to
36 manufacturing, the extraction of raw materials, processing, warehousing, and transportation.
37 Hence, for large multinational companies that manufacture complex products supply chains are

1 highly complex socioeconomic systems. There are many players in the medical supply chain;
2 however, manufacturers and distributors are particularly prominent.

- 3
- 4 • Manufacturers are the first link in the supply chain and make the medicines and health care
5 supplies patients and physicians rely on. Manufacturers acquire raw materials for
6 production of approved products; conduct research, develop, and process medicines and
7 products; identify what product(s) is needed and if enough supply will be available based
8 on demand; conduct safety trial testing; and package approved products for distribution.
- 9 • Distributors are the second link in the medical supply chain. Distributors repackage,
10 relabel, and ensure special handling for unique products; obtain medicines and products
11 from manufacturing facilities and distribute to providers, health care facilities or other
12 general areas of need; and manage temperature and climate conditions for safe
13 transportation of medicines and products. Distributors purchase drugs and medical
14 products in bulk from manufacturers and maintain large stocks in strategic locations across
15 the country. Some wholesalers specialize in dealing with a particular range of products,
16 such as biologics or to specific types of customers.
- 17 • Providers (hospitals, pharmacies, dialysis centers, urgent care, assisted living, and long-
18 term care facilities) submit orders to distributors; refill prescriptions for patients; and
19 identify shortages in inventory and potential distribution challenges.
- 20 • Patients and communities with unique medical needs that require specific products
21 influence the demand for medicines and products.
- 22

23 To strengthen and stabilize the medical supply chain, it is important to understand the various
24 aspects of the medical supply chain, to identify the challenges that resulted in supply chain
25 disruptions during the pandemic, and to consider several strategies to mitigate medical supply
26 chain disruptions for the future.

27 28 GLOBALIZATION OF U.S. MEDICAL SUPPLY CHAIN

29
30 Over decades, the medical supply chain has assembled substantial global networks; however, the
31 COVID-19 pandemic has exposed structural weaknesses and cracks within these networks. Many
32 medical supply distributors and health systems had adopted a “just-in-time” approach to supplies,
33 by which they stocked only what they immediately needed and trusted supply chains to deliver
34 other items quickly. That approach saved money because firms and hospitals did not need to build
35 extended storage facilities or keep full inventories. Rather, they kept their stocks low and refreshed
36 on an “as needed” basis.³ At the same time, much of America’s manufacturing capacity shifted
37 abroad, where products could be made inexpensively with low labor and energy costs.⁴ Further,
38 while American manufacturing’s share of overall output remained constant, its labor share declined
39 as firms automated production lines and relied upon emerging technologies.⁵ That production and
40 distribution system worked as planned until issues in the global supply chain disrupted those
41 practices, creating problems in terms of supply, safety, and security.

42
43 The National Academies of Sciences, Engineering, and Medicine (NASEM) reported that only
44 28% of the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S.
45 market were in the United States as of August 2019. This means that 72% of the medical supplies
46 and APIs for making drugs found in the United States had resulted from outsourcing to other
47 countries. A previous shortfall occurred with the anticoagulant heparin, made using pig intestines:
48 China makes 80% of the world’s heparin and 60% of the U.S. supply. In 2007, an infectious
49 disease outbreak in Asia decimated pig herds, pushing heparin into short supply and doubling
50 prices. Seeking a rapid, practical solution, the U.S. Food and Drug Administration (FDA)

1 suggested using U.S. bovine heparin and asked manufacturers to submit applications that
2 demonstrated safety, efficacy, quality, and purity. Although the FDA cannot eliminate all possible
3 risk, it can enforce requirements, controls, and best practices to detect problems early while
4 ensuring the availability of safe and effective medications.⁶

5
6 As COVID-19 became a pandemic, different countries took steps to protect their local supplies by
7 limiting or stopping exports entirely. For example, China, which produces roughly 50% of the
8 global supply of masks at 10 million masks daily, ramped up production to 115 million daily
9 during the early phases of COVID-19, yet simultaneously terminated all mask exports, leading to a
10 gradual depletion of global stockpiles. Additionally, Germany banned the export of most of its PPE
11 supplies. In other areas where local production was not significant, essential equipment
12 procurement became vulnerable.

13
14 Virus mitigation measures continue to affect production and limit efforts to return the supply chain
15 to pre-pandemic levels. Several industry players have reduced worker levels due to fears of the
16 further spread of COVID-19 within the workplaces. In China, port terminals temporarily closed
17 because of the country's COVID-19 zero-tolerance policy, creating lengthy shipping backlogs at
18 some of the world's largest ports. While consumer demand can increase in months, more time is
19 required to increase port capacity, build warehouses, and hire employees so that shipping can meet
20 the needs of the demand.

21
22 Problems include a wide array of medical supply and equipment shortages that can be traced to
23 component scarcities, factory closures, backlogged ports, transportation glitches, and COVID-19
24 lockdowns across the global supply chain. According to the FDA, the list of persistently scarce
25 items is long and includes latex and vinyl examination gloves, surgical gowns, laboratory reagents,
26 specimen-collection testing supplies, saline-flush syringes, and dialysis-related products.⁷

27 CAUSES AND CONSEQUENCES OF MEDICAL SUPPLY CHAIN FAILURES

28
29
30 Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical
31 conflict, economic conditions, and quality-related issues at production sites. These factors can
32 impact daily health care, as well as the profitability of manufacturing companies. Once there is an
33 infectious outbreak, it may be difficult to access treatment and other health services, especially if
34 the outbreak comes with harsh control measures such as quarantines and lockdowns. Such
35 measures may generate an acute surge in the demand for critical medical supplies and equipment,
36 which exceeds supply, leading to shortages and protocols for prioritized use. A disruptive event can
37 cause a mismatch between supply and demand in medical product supply chains in three ways:

- 38
39 1. Demand surge: An event drives demand for a medical product well above the normal
40 level for an extended period. For example, a major natural disaster, such as a tornado or
41 earthquake, can spike regional demand for certain medical products if these events result
42 in a significant number of casualties requiring medical care. As seen during COVID-19,
43 a pandemic can drive up global demand for many medical products.
- 44 2. Capacity reduction: One or more production or transport processes are impeded by lack
45 of assets, power, or people. For example, a natural disaster could cause a factory to lose
46 power and halt production, or regulatory barriers or manufacturing quality problems
47 could restrict the output of a supplier or producer and could even eliminate inventory
48 stock if a product is recalled. As seen during the COVID-19 pandemic, production of
49 some products decreased because of lockdown measures, as well as acute loss of
50 workers to quarantine and illness.

- 1 3. Coordination failure: Events that prevent coordination of supply to meet demand can
2 cause shortages of medical products even when total supply is sufficient to meet total
3 demand. For example, geopolitical issues or communication system failures during a
4 hurricane or other natural disaster can reduce or obstruct the delivery of emergency
5 supplies into a city or region.⁸
6

7 The COVID-19 pandemic led to such shortages in medical supplies as a combination of all three
8 ways, leading to gaps in medical supplies for routine health care (e.g., dialysis-related products)
9 and pandemic response (e.g., PPE, lab testing supplies and equipment, and ventilation-related
10 products) in most health care facilities around the world.

11
12 The medical supply chain may be influenced by U.S. insurance companies, hospitals, physicians,
13 employers, and regulatory agencies, with differing objectives among them. Demand for services is
14 determined by both available treatments and insurance coverage for those treatments. Decisions
15 made by one party often affect the options available to other parties, as well as the costs of these
16 options, in ways that are not well understood. Most of these complicated factors are also present, to
17 varying degrees, in industrial supply chains.

18
19 In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring
20 needed supplies, including shortages of key items and significant price increases. A Kaufman Hall
21 report noted that 80% of hospitals had significant supply shortages and had to seek new vendors for
22 supplies during the pandemic. Shortages in raw materials and components hampered the production
23 of both drugs and sophisticated medical devices. Manufacturing facilities struggled to keep up as
24 COVID-19 swept through the workplace. Labor shortages prevented medical products from being
25 transported to the places where they were needed most.⁹
26

27 Helium, a nonrenewable element found deep within the earth's crust, is essential for keeping
28 magnetic resonance imaging (MRI) machines cool enough to work. With a boiling point of minus
29 452 degrees Fahrenheit, liquid helium is the coldest element on Earth. Pumped inside an MRI
30 magnet, helium lets the current travel resistance-free. However, the supply of helium is running
31 low leaving hospitals wondering how to plan with a much scarcer supply. Currently, four of five
32 major U.S. helium suppliers are rationing the element.¹⁰ Shortages in aluminum, semiconductors,
33 wood and paper pulp, and resin are disrupting supplies of medical devices, with different business
34 sectors competing for the same raw materials. Those shortages have led to uneven supplies of
35 medical monitors, CT scan devices, packaging for medical supplies, and gloves. While only a
36 fraction of the world's semiconductors is in medical equipment compared with cars and consumer
37 electronics, the components are key to a range of medical devices such as MRI machines,
38 pacemakers, glucose monitors, CT scanners, defibrillators, multiparameter monitors, and
39 ultrasound machines. As a result, hospitals are experiencing long order delays for equipment
40 because of the semiconductor shortage.¹¹
41

42 Drugs used in the United States involve raw materials from all over the world. Many chemical
43 inputs are manufactured in India and China and then shipped to the United States. Regardless of the
44 root cause, drug shortages can lead to substitutions for available medications that are costlier and/or
45 less effective. In some instances, hospital pharmacies must compound and modify products, which
46 adds workload and potential error.¹² The American Medical Association (AMA) Council on
47 Science and Public Health (CSAPH) has issued eleven reports on drug shortages. AMA Policy H-
48 100.956, "National Drug Shortages," directs the CSAPH to continue to evaluate the drug shortage
49 issue and report back at least annually to the House of Delegates on progress made in addressing
50 drug shortages in the United States. CSAPH Report 01-I-22 provides an update on continuing

1 trends in national drug shortages and ongoing efforts to further evaluate and address this critical
2 public health issue.¹³

3
4 The United States recently experienced a surge in respiratory illnesses, a potential “triple-demic” of
5 three viruses: respiratory syncytial virus the influenza virus, and the COVID-19 coronavirus. While
6 antibiotics like amoxicillin typically are not effective against such respiratory viruses, they can be
7 important treatments for secondary bacterial infections that may occur when respiratory tract
8 defenses and the immune system in general are battling a viral infection. Despite the best efforts to
9 address root causes of drug shortages, the United States has a dysfunctional, opaque medical
10 supply chain. There is still no easy way to scale up production to meet excess demand. Moreover,
11 there remains a limited profit motive to do better, particularly for low-cost medications such as
12 amoxicillin.

13 14 U.S. GOVERNMENT ACTIONS TO MITIGATE MEDICAL SUPPLY CHAIN ISSUES

15
16 During the COVID-19 public health emergency, the FDA took many actions to ensure that health
17 care professionals had timely and continued access to high-quality medical devices. These actions
18 included *Emergency Use Authorizations*) and guidance permits to expand available resources for
19 diagnostic, therapeutic, and medical devices in high demand. Further, President Trump invoked the
20 *Defense Production Act* and released government funds to help American companies build
21 facilities and expand production capabilities for medical equipment.¹⁴

22
23 In October 2020, in response to Executive Order 1394410, the FDA published a *List of Essential*
24 *Medicines, Medical Countermeasures, and Critical Inputs* (described herein as EM). This
25 executive order sought to ensure sufficient, reliable, and long-term domestic production of these
26 products and minimize potential shortages. The published EM list contained 227 drug and
27 biological product essential medicines and countermeasures, including analgesics, antivirals,
28 anticoagulants, antihypertensives, and antimicrobials.¹⁵ The *Center for Drug Evaluation and*
29 *Research (CDER) Site Catalog* includes approximately 1,100 locations that manufacture at least
30 one product on the EM list. There are 1,686 sites that manufacture an active pharmaceutical
31 ingredient (API), of which 354 manufacture API for EM products. Currently, 23% of API
32 manufacturing sites are in the United States; for EM, this drops to 19%. These data illustrate that
33 only a minority of drug manufacturing sites are domestic. Overall, API and finish dose form
34 manufacturing are heavily dependent on foreign manufacturing sites.

35
36 Since early 2020, the United States has made progress in strengthening the health care supply chain
37 by addressing concerns regarding domestic manufacturing and supply chain surge capabilities. In
38 2021, President Biden issued Executive Order (EO) 14017, *On America’s Supply Chains*. The 100-
39 Day Review under this order directed the U.S. Department of Health and Human Services (HHS)
40 to identify products for which onshoring (bringing production back to the U.S.) may be advisable.
41 HHS subsequently issued a 2022 report that identifies successes and practical strategies to further
42 U.S. goals for America’s supply chain and industrial base. Particular efforts should be directed at
43 expanding the public health industrial base by working across government agencies, academia, and
44 the private sector, and strengthening capabilities to monitor and manage supply chain bottlenecks.¹⁶
45 Note that Section 510(j)(3) of the *Food, Drug and Cosmetic (FD&C) Act*, which was added by the
46 recent *CARES Act*, requires FDA registered sites to report annually the amounts of drugs
47 manufactured for U.S. commercial distribution. Combined with FDA information about the
48 location of manufacturing sites, these data should enable the FDA to perform better manufacturing
49 site surveillance.¹⁷

1 In 2020, the FDA reported 43 new drug shortages after a peak of 251 shortages in 2011.¹⁸ On the
2 surface, this looks like tremendous progress; however, this measurement does not consider the
3 scope, scale, or severity of the shortage. The FDA metric measures every shortage the same way,
4 whether a drug is dispensed 20 times or 20,000 times a month. Moreover, not every shortage is the
5 same. In response to the public health crisis, some U.S. hospital groups, startups, and nonprofits
6 began making their own sterile injectables and other medicines as a short-term workaround to
7 combat persistent drug shortages.¹⁹ Experts anticipate that efforts by hospitals to have more direct
8 control over their critical drug supply chains will continue to evolve as they work to find a
9 sustainable, cost-effective, and safe model. Joint public-private sector efforts, such as the creation
10 of a *Strategic Active Pharmaceutical Ingredient Reserve (SAPIR)*, will be instrumental in defining
11 how these products are supplied in the future.²⁰

12
13 The 2013 *Drug Supply Chain Security Act (DSCSA)* outlines steps to build an electronic,
14 interoperable system to track and trace prescription drugs.²¹ The original aim of the DSCSA was to
15 enhance the ability of the FDA to regulate drug safety and help protect patients. However, this
16 system could improve the management of drug product shortages as well.²² Serialization
17 (assignment of a unique serial number to each supplyable prescription product) in the drug supply
18 chain could vastly improve an organization's ability to manage inventory. A pilot DSCSA program
19 with the FDA showed the potential for using IBM blockchain technology to connect disparate data
20 for tracking and tracing prescription medications and vaccines in the United States.²³

21
22 In 2022, the NASEM published the congressionally mandated report, *Building Resilience into the*
23 *Nation's Medical Product Supply Chains*. The report called for the FDA to track sourcing, quality,
24 volume, and capacity information, and to establish a public database for health systems, inclusive
25 of failure-to-supply penalties in contracts. In addition, the report recommended that the federal
26 government optimize inventory stockpiling to respond to medical product shortages.²⁴

27
28 While the federal government can generate greater economies of scale for the procurement of
29 health care supplies during a pandemic, local governments can identify lower socioeconomic
30 groups and minorities that are particularly vulnerable to both the health and economic aspects of a
31 pandemic. As a result, they can employ resources more efficiently for a rise or fall in cases and
32 hospitalizations.

33 34 ONSHORE AND NEARSHORE STRATEGIES

35
36 Concerns unleashed by the pandemic and dependence on foreign manufacturers combined to
37 increase risks and raise doubts regarding "just-in-time" practices.²⁵ The disruptions caused by this
38 approach have led to calls for greater domestic manufacturing capability through onshoring or
39 reshoring (bringing production back to the United States) or nearshoring (bringing production back to
40 friendly countries not far from the United States, such as Canada and Mexico). A European
41 Parliament report found modest benefits to reshoring in the United Kingdom, United States and
42 Japan and argued that reshoring should be primarily focused on specific critical sectors and
43 products with pronounced supply bottlenecks, rather than across-the-board. Targeted reshoring was
44 advised because host countries often do not have the production facilities and/or workforce
45 required for wholesale reshoring.²⁶ Both onshoring and nearshoring should consider the ownership
46 of the manufacturing: a foreign company can own domestic manufacturing facilities and still
47 monopolize production.

48
49 One of the key areas affected by the pandemic was the API market. Research by McKinsey shows
50 that supply chains in the pharmaceutical industry are more global than in other sectors, and there is
51 a tendency to source certain materials from a particular region. For instance, 86% of the

1 streptomycin in North America and 96% of the chloramphenicol in the European Union come from
2 China. Diversifying supply chain materials is an option that pharmaceutical companies could
3 pursue to reduce their exposure through onshoring. McKinsey estimates that 38% to 60% of the
4 international pharmaceutical trade, worth \$236 billion to \$377 billion in 2018, could be considered
5 for onshoring. Locally sourced API production will likely become an increasingly important part of
6 government policy and pharmaceutical company commercial strategy. However, diversifying
7 supply chains is expensive, and the cost of reconfiguring them will fall on consumers or
8 governments. Further, the risk from regional domestic disasters in the vicinity of manufacturing
9 and distribution facilities must be assessed.²⁷

10
11 The United States once led the world in semiconductor manufacturing yet has fallen behind. Other
12 countries, especially in Asia, made deliberate investments to build powerful chipmakers in their
13 own countries. Foreign state subsidies created a ~30% cost advantage for foreign chipmaking
14 plants, and the resulting advantage is startling: in 1990, the United States supplied 37% of the
15 world's chips, but now only 11%. This outcome has undermined U.S. technology leadership with
16 significant economic and national security implications: a recent White House study concluded that
17 "our reliance on imported chips introduces new vulnerabilities into the critical semiconductor
18 supply chain."²⁸

19
20 In 2019, the U.S. medical end-use market accounted for \$5.6 billion in total semiconductor sales—
21 roughly 11% of the global industrial semiconductor market and 1.3% of the total semiconductor
22 market. However, 47% of the chips sold worldwide are designed in the United States. Meanwhile,
23 the medical semiconductor segment is growing faster than the overall industrial semiconductor
24 market, which is driven by long-term trends of an aging population, the rise of telehealth, the move
25 to portable and wearable devices, and the applications of artificial intelligence.²⁹ Despite being a
26 small percentage of the overall semiconductor chip market, there is an urgent need for chips in
27 medical device manufacturing.³⁰

28
29 Recognition of chip vulnerabilities led Congress to pass and President Biden to sign the *CHIPS and*
30 *Science Act* in August 2022. This law provides \$52.7 billion in aid to the semiconductor industry
31 along with other incentives to build new semiconductor production facilities in the United States.³¹

32 33 OPPORTUNITIES TO IMPROVE MEDICAL SUPPLY CHAIN PERFORMANCE

34
35 Since disruptions in medical supply chains have the potential to seriously impact patient care and
36 safety, health care systems need the capacity to proactively foresee, absorb, and adapt to shocks
37 and structural changes in a way that allows them to sustain required operations, resume optimal
38 performance as quickly as possible, transform their structure and functions, and reduce their
39 vulnerability to similar shocks and structural changes in the future.³² Most experts agree that
40 stakeholders must come together to develop consistent, meaningful metrics that reflect a
41 sophisticated approach to managing and preventing shortages that pose risks to health care systems
42 and patients.

43
44 There are several automated technologies available that health care systems can use to quickly
45 access data and projections:

- 46
47 • Cloud-based, radio-frequency identification (RFID) technology allows for real-time
48 tracking that prevents shortages while enabling health care professionals to view their
49 inventory quickly and accurately.

- 1 • By tapping into the Internet of Things, internet-connected medical devices and equipment
2 enable different systems in health care organizations to speak to one another and ensure
3 information is updated across departments rather than being held up in siloes.
- 4 • A third option are analytics platforms, powered by artificial intelligence (AI), e.g., an
5 electronic health record (EHR) embedded in an AI platform. On these platforms,
6 cataloging allows users to distribute and curate all analytics in a single web-based action.
7 Users may also have access to benchmarking data so they can analyze their overall
8 performance.³³

9
10 In a recent McKinsey survey of U.S. health system and supply chain executives, nearly three-
11 quarters of survey respondents agreed that “the supply chain stands to assume an even more
12 strategic role.” Three themes emerged as critical to a high-performing supply chain function:
13

- 14 • *Engage front-line physicians in supply decisions.* In high-performing organizations,
15 physicians play an integral role in supply chain initiatives: they provide input on supplier
16 selection and contracting strategies, including their financial impact; they support
17 compliance with contract terms (for example, by committing to give a supplier a negotiated
18 share of business); they manage the use of supplies; and they contribute to achieving
19 financial, quality, or other goals.
- 20 • *Jointly set goals across facilities and functions.* Supply chain initiatives may require
21 meaningful changes in behavior by some clinicians, including shifting away from their
22 suppliers of choice to clinically similar suppliers used by their peers. To assist this change,
23 systems may consider providing incentives, which can be financial or nonfinancial and
24 may include a commitment to reinvest a percentage of savings in priorities of physicians.
- 25 • *Invest in accurate, actionable data and analytics.* Analytical tools are only useful if they
26 provide relevant insights to their users, which may require individual customization and,
27 for convenience, accessibility on multiple devices. For example, a supplies cost-per-case
28 tool, which shows the cost of all supplies for a given operating-room procedure, should
29 provide the relevant views for physicians so that they can see the supplies they use, cost
30 compared to supplies used by peers, alternative supply options, and quality outcomes.³⁴

31
32 At the 2019 Association for Health Care Resource & Materials Management conference of the
33 American Hospital Association, speakers emphasized eight points to strengthen relationships
34 between physicians and PURE (Physicians Understanding, Respecting, and Engaging Supply
35 Chain) professionals:
36

- 37 • *Share meaningful data with physicians.* Physicians are empiricists, motivated by data. As a
38 result, health systems should provide meaningful data at a consistent cadence to
39 physicians, perhaps quarterly.
- 40 • *Welcome partnerships in achieving the strategic goals of the organization.* Hospital
41 systems that work with independent physicians should bring them into supply chain
42 decision-making to include clinical perspectives.
- 43 • *Use evidence-based principles to guide decision making.*
- 44 • *Place some restriction on the number of vendors used.* However, be mindful not to limit
45 physician preference items completely or force surgeons to use specific or substandard
46 products.
- 47 • *Provide context for supply chain decision making.* Organizations should be very
48 transparent regarding what relationships drive their supply chain decision-making, to
49 include the use of group purchasing organizations (GPOs). Physicians understand

- 1 economies of scale, price sensitivity and market trends, and want to play a role in finding
2 solutions.
- 3 • *Include practicing physicians as part of the decision-making team.* Many hospital
4 administrators do not have clinical backgrounds or currency, so it is important to have
5 physicians with clinical experience on supply chain leadership teams. Physicians can share
6 clinical insights to inform supply chain discussions, translate clinical and supply chain
7 languages, and provide credibility for communication with physicians.
 - 8 • *Update clinical pathways to include product categories that support evidence-based
9 medicine and minimize clinical variation.* Data should be used to create algorithms and
10 care pathways for high-volume procedures.
 - 11 • *Emphasize that supply chain sustainment needs logisticians and physicians.* Collaboration
12 is essential to anticipate and fulfill supply needs with timeliness and realism.³⁵

14 FUTURE OF THE MEDICAL SUPPLY CHAIN: IMPROVED TECHNOLOGY AND 15 PROCESSES, AND SITUATIONAL AWARENESS

16
17 While the pandemic caused major disruptions in health care with severe consequences, it also
18 spurred medical and technological innovations. Telemedicine has become common, medical
19 professionals have urged adoption of new models of care, shifting from cost-efficiency to long-
20 term planning, and public-private partnerships have been formed to deal with current and future
21 crises. One of the highest priorities for the medical supply chain is expansion, which includes more
22 than the expansion of infrastructure and transportation in areas that have less accessibility. Patient
23 care has historically been limited to a person's ability to arrive at a hospital or care facility and
24 restricted by the supply chain's capacity to provide swiftly the correct product for that patient's
25 individual need. Technology has recently enhanced treatment products to allow patients to receive
26 care outside of a traditional care facility. A patient's treatment can now follow them outside of a
27 hospital or medical practice with the use of telehealth communication, at-home testing kits, and at-
28 home treatment that can be sent right to the patient's door. This requires the medical supply chain
29 to extend past hospitals and include last-mile transportation to patients so that they do not have to
30 return to the hospital. At-home patient care also requires more treatments to become personalized.
31 The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be
32 provided while saving manufacturing costs.

33
34 As physicians and health care organizations adapt to newer data processing capabilities, they can
35 more readily keep their information correct and consistent. Predictability is a must as we continue
36 to move towards standardizing patient experience and more at-home care. The medical supply
37 chain will need to implement strategies that help it become more predictable to physicians and
38 health care organizations who need high visibility on their needed products. Currently, medical
39 supply chain management lacks a unified, well-adopted data standard. The Global Trade Item
40 Number (GTIN) standard is available, but adoption rates remain low compared to the universal
41 product code (UPC) fully adopted in other industries. Clinical and regulatory requirements
42 necessitate tracking of device information through the supply chain and in clinical EHR systems.
43 Supply chain intermediaries bear responsibility for efficient supply chain integration.

44
45 Data will be utilized to anticipate product demand. Clean data will also help supply chains stay
46 agile and not allow disruptions to hold up the services they are working to provide. Discontinued or
47 back-ordered products can greatly disrupt a supply chain, though when such things can be more
48 easily resolved with data analysis, the supply chain can become much more predictable. Data usage
49 is one strategy that will help supply chain predictability, and several strategies can help a supply
50 chain stay consistent and save costs. Some strategies for resilience include expanding domestic

1 supply chain production, making product allocation needs-based, and increasing trust. The medical
2 supply chain will have data that, if it is fully captured and analyzed, will be essential for decision
3 making. Organized collection of data can greatly impact every stage of the supply chain, as each
4 segment can make predictions based on past data and optimize processes.

5
6 Data can greatly enhance a company's capacity to be proactive, and predictive analytics can
7 amplify that capability. Predictive analytics will help the supply chain with decision-making and
8 offer a clear way to see the ebb and flow of supply and demand. Companies can use predictive
9 analytics in new ways that help bring visibility to inventory and ensure the right products are being
10 ordered and priced correctly and that there are enough items to meet demand. Predictive analytics
11 can also help companies be more proactive in situations that significantly impact the medical
12 supply chain. The COVID-19 pandemic created new aspects of health care to predict, like the
13 number of COVID-19 cases, and the number of patients needing treatment. Predictive analytics can
14 help companies prepare for these unforeseen circumstances and prepare the supply chain for future
15 unknowns.

16
17 The use of artificial and augmented intelligence (AI) is growing throughout the health care
18 industry: AI is being used to clean data and promote efficient human effort. There are even more
19 ways that AI can be used to enhance health care and save costs. AI and predictive analytics—while
20 being used nominally right now by physicians and health care organizations—can, should and will
21 be used to ensure the right items, from the right sources, at the right prices for the right outcomes
22 are ordered at the right times and in the right quantities to prevent shortages and price gouging.
23 This will help to ensure financial stability of medical practices and health care organizations, while
24 mitigating patient risk. AI can help supply chains keep up demand, by recommending stand-in
25 products if the preferred product is not available. AI algorithms can be used to fill the gap between
26 supply and demand while saving costs and eliminating human error.

27
28 Many health care organizations are addressing supply chain challenges with holistic solutions that
29 pair technology with other changes. For the supply chain to function efficiently, physicians need to
30 be involved in decision-making. Increasing supply chain resilience requires fostering an
31 organization-wide commitment from leaders to staff members and by investing time and resources
32 necessary to identify and address the root causes of supply chain challenges. Although technology
33 is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear
34 to address weaknesses may only partially fix the issues. Comprehensive solutions that position
35 technology as a component alongside people and processes can help make the medical supply
36 chain more resilient. Several large health care organizations across the country have developed
37 partnerships with shared goals and vision between physicians and hospital administrations. What is
38 necessary to further these efforts is an investment in evidence tools and the creation of a physician
39 role in the supply chain, which is becoming more common.

40
41 Some disruptions in a patient's care can be attributed to limited situational awareness between
42 physicians and the supply chain. When physicians do not have knowledge of the products in the
43 supply chain, they cannot provide the best treatment possible. When the supply chain lacks clear
44 communication with physicians, medical practices, and health care facilities, it is difficult to know
45 the demand for products and when they should arrive. The future of the medical supply chain
46 entails transparent communication of supply chain issues and patient needs between suppliers and
47 health care professionals. Supply chain professionals and physicians can work together to create
48 methods that enhance situational awareness. Physicians can articulate needs, and medical supply
49 chain professionals can provide information about the prices of products and transportation,
50 outcomes, and alternative options for their products. Addressing these issues can improve the
51 relationship between the supply chain and physicians and health care organizations. The medical

1 supply chain can gain physician trust by communicating regularly and providing insight into the
2 inner workings of logistics.

3
4 Adaptability and efficiency are crucial in today's health care supply chain environment. If a
5 company's methods are too rigid, it will not be able to adapt quickly to unexpected changes.
6 Furthering relationships between clinicians and suppliers will help a supply chain boost its
7 robustness. Having trusting relationships between distributors and manufacturers, as well as
8 effective contracting models, will create a strong network within the health care supply chain that
9 can adapt smoothly while providing the most efficient services possible. Effective supply chain
10 performance directly links to patient outcomes and clinical safety, influencing much more than
11 PPE. Prior to the COVID epidemic, many physician leaders recognized the value of supply chain
12 excellence; that value is now apparent to all physicians.

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REPORT 06 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Health Care Marketplace Plan Selection
Informational Report

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, “Health Care Marketplace Plan Selection.” This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes key AMA policies that strongly support competition and choice in the health insurance marketplace.

Insurer participation in the Affordable Care Act (ACA) marketplace has increased for five consecutive years, enrollment has surpassed 16 million people, and the exchanges are generally functioning well. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA’s most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions.

The Council finds that the concerns raised in Policy D-165.933 are addressed by Policies H-165.825, H-165.839, H-165.838, H-165.846, H-180.946, H-165.856, and H-180.947. We identify no gaps in existing AMA policy and make no recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the marketplace, remains problematic and is worthy of additional study. The Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 06-A-23

Subject: Health Care Marketplace Plan Selection

Presented by: Lynn Jeffers, MD, Chair

1 At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, “Health Care
2 Marketplace Plan Selection.” This policy directs the American Medical Association (AMA) to
3 re-evaluate and study the effectiveness of the current plan options in the health care marketplace to
4 adequately provide choice and competition, especially in communities in close proximity to
5 multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023
6 Annual Meeting. This report, which is presented for information to the House of Delegates,
7 provides updated information on insurer competition in health insurance exchanges, insurer
8 concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally,
9 the report summarizes AMA policy that strongly supports competition and choice in the health
10 insurance marketplace.

11

12 BACKGROUND

13

14 The intent of individual health insurance exchanges required under the Affordable Care Act (ACA)
15 is to broaden coverage through a patient-friendly market and ensure healthy competition among
16 plans. Products sold in the ACA marketplace are required to be certified as qualified health plans
17 (QHPs); and as a condition of QHP certification, insurers—or issuers—must meet certain standards
18 and requirements designed to protect patients while encouraging health plan competition and
19 choice. Robust competition among issuers participating in the insurance exchanges is essential to
20 health plan affordability and choice, as evidenced by research showing that the participation of
21 additional insurers on an exchange is associated with lower premiums and, conversely, regions
22 with fewer insurers have higher premiums.¹ Across states, there is significant variation in the
23 number of insurers and plans offered in ACA exchanges and, within states, there may be
24 differences in insurer participation in rural and urban areas.

25

26 INSURER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

27

28 Insurer participation in the marketplace has been an ongoing concern since the ACA exchanges
29 began operating and have gone up and down in the ensuing years in response to marketplace
30 regulations and insurers entering and exiting the market. After a period of decreasing insurer
31 participation between 2016 and 2018 (participation was at its highest in 2015), 2023 marks the fifth
32 consecutive year of increases in the number of insurers offering ACA marketplace plans. In fact,
33 most people shopping for coverage on an exchange must navigate through scores of offerings
34 before choosing a health plan that best meets their needs and budget, a process that can be both
35 daunting and confusing. This year, consumers using the federal exchange through HealthCare.gov
36 will have, on average, more than 113 QHPs to choose from, up from over 60 plan options in 2021
37 and just over 25 options in 2019.² An issue brief released by the Office of Health Policy for the
38 Assistant Secretary for Planning and Evaluation (ASPE) showed that, in 2021, nearly three-
39 quarters of HealthCare.gov users had more than 60 plan options to choose from, and over a quarter
40 selected from more than 160 plans.³ Within a specific metal tier (i.e., bronze, silver, gold, or

1 platinum), or even within a particular metal tier and a specific issuer, consumers in many areas can
2 still have an abundance of plan options from which to choose.

3
4 In the 33 marketplaces using the HealthCare.gov platform, the Centers for Medicare & Medicaid
5 Services (CMS) has announced that there is greater choice of insurers in 2023 with only one
6 percent of enrollees having access to a single QHP issuer, the lowest in marketplace history.⁴ The
7 Center for Consumer Information and Insurance Oversight (CCIIO) has reported that, in
8 HealthCare.gov states, 92 percent of enrollees have three or more insurers from which to choose
9 this year compared to 89 percent of enrollees in 2022. There are 220 total insurers participating in
10 HealthCare.gov states, an increase of seven from 2022, and the average enrollee has access to
11 between six and seven issuers, and over 113 QHPs.⁵ A CCIIO [map](https://www.cms.gov/files/document/py2023-county-coverage-map.pdf)
12 (<https://www.cms.gov/files/document/py2023-county-coverage-map.pdf>) of Plan Year 2023
13 exchange insurers, which includes federally-facilitated exchange data as well as self-reported data
14 (updated as of October 2022) from the 18 states operating their own exchanges, shows that only
15 three percent of counties (93) have a single insurer while 25 percent (771) have two insurers and
16 remaining counties have three or more insurers on the exchange. This contrasts with 2018 when
17 over half (51.3 percent) of counties had a single carrier, a percentage that decreased to just over 35
18 percent of counties in 2019, 24 percent in 2020, nine percent in 2021, five percent in 2022, and
19 three percent in 2023 (see appendix). County level data is important to measuring competition in
20 the ACA marketplace because many insurers offer plans in some parts of a state but not others, and
21 because health plans are priced and offered locally.

22
23 A brief from the Robert Wood Johnson Foundation explains that although insurer participation in
24 the ACA marketplace increased significantly between 2019 and 2021, such increases were more
25 moderate in 2022 and relatively small in 2023.⁶ This year, large increases in insurer participation
26 were seen in only a small number of states, including a few non-expansion states, as insurers
27 continue to focus on areas where more uninsured people live. Although Georgia had a large
28 increase in new plan offerings in 2022, the increase in that state was much smaller in 2023 when
29 Texas had the most new offerings.⁷ Importantly, the share of plans offered by large health insurers,
30 including Blues plans, UnitedHealthcare, Cigna, CVS/Aetna, Centene, and Molina, increased in the
31 marketplace while the share of smaller insurers, such as regional and provider-sponsored plans,
32 decreased from 45 percent in 2022 to 40 percent in 2023.⁸ Furthermore, the large national insurers
33 have tended to take over where smaller companies, including Bright Health and Oscar Health, have
34 exited markets. It is also notable that the Medicaid managed care companies Centene and Molina
35 have been steadily increasing their footprints on the exchanges.

36 37 INSURER CONCENTRATION IN EXCHANGE MARKETS

38
39 The 2022 edition of the AMA's *Competition in Health Insurance: A Comprehensive Study of U.S.*
40 *Markets* notes that there have been large changes over time in exchange market concentration and
41 some volatility in exchange insurers' market shares and rankings. According to the study's
42 analysis, there were large increases in average market concentration in the exchanges between 2015
43 and 2018, annual decreases thereafter, and a notably large decrease between 2020 and 2021 that
44 was widespread across metropolitan statistical areas (MSAs). The AMA study found that, at the
45 MSA level in 2021, at least one insurer had a market share of 30 percent in 98 percent of exchange
46 markets; in 73 percent of markets, one insurer had a market share of 50 percent; and in 39 percent
47 of markets, an insurer had a market share of 70 percent.⁹ Turning to the national level, Anthem had
48 the largest share of the exchange market in 2014 and 2015 but fell to sixth largest in 2021 while
49 Centene, which had a smaller share of the exchange market in earlier years, had the largest market
50 share (15 percent) in 2021.¹⁰

1 Concerns over the years regarding insufficient competition in the individual health care
 2 marketplace have led some thought leaders, as well as state and federal policy makers, to put
 3 forward a range of proposals to ensure marketplace coverage options, including the creation of a
 4 public option. Concerns with public option proposals have previously been addressed at length by
 5 the Council on Medical Service in [Council Report 3-A-18](#) and [Council Report 1-Nov.-20](#). Policy
 6 experts have also suggested leveraging Federal Employees Health Benefits Program (FEHBP)
 7 health plan participation as a solution to prevent bare counties in the marketplaces, which is
 8 consistent with Policy H-165.825. In addition to discussing a public option and establishing policy
 9 that supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to
 10 offer at least one silver-level marketplace plan as a condition of FEHBP participation, Policy
 11 H-165.825—established via [Council on Medical Service Report 3-A-18](#)—supports health plans
 12 offering coverage options for individuals and small groups competing on a level playing field,
 13 including providing coverage for pre-existing conditions and essential health benefits. This policy
 14 also opposes the sale of health insurance plans in the individual and small group markets that do
 15 not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits
 16 and their associated protections against annual and lifetime limits, and out-of-pocket expenses,
 17 except in the limited circumstance of short-term limited-duration insurance offered for no more
 18 than three months.

19
 20 A primary purpose of regulations governing the health insurance marketplace has been to help
 21 ensure that insurers are competing and operating on an even playing field in which all insurers and
 22 plans must play by the same rules. The AMA advocates that exchanges need to offer choices to
 23 patients to spur competition and that mechanisms to facilitate competition in health insurance
 24 should ensure that critical patient protections remain in place, including the ban on pre-existing
 25 condition exclusions as well as critical cost protections guaranteed in the ACA (e.g., annual cap on
 26 out-of-pocket expenses). The AMA strongly believes that an important federal role remains to
 27 ensure that proposals to foster competition in health insurance also promote ACA marketplace
 28 stability and a balanced risk pool and do not lead to adverse selection in the marketplace.¹¹

29
 30 NETWORK ADEQUACY

31
 32 AMA policy and advocacy also underscores that a plan’s provider network is an important factor in
 33 maintaining healthy competition and choice and, as such, the AMA consistently advocates for
 34 stronger network adequacy standards for QHPs, including those offered through federally
 35 facilitated exchanges. The AMA believes that state regulators should have flexibility to regulate
 36 their provider networks but also maintains that there is a critical need for a minimum federal
 37 network adequacy standard that includes quantifiable standards, especially in light of inaction in
 38 many states to update network adequacy requirements. The AMA has also advocated that CMS
 39 implement additional qualitative standards to measure network adequacy and better evaluate access
 40 to timely and appropriate care for enrollees in QHP plans.¹²

41
 42 In response to CMS’ proposed rulemaking on benefits and payment parameters under the ACA for
 43 2024, the AMA strongly supported CMS’ inclusion of wait time requirements into the
 44 measurement of network adequacy. The AMA believes this, and other quantitative standards are
 45 critical to determining if a network can serve the needs of its enrollees. Often network physicians
 46 may appear to be available but may not be accepting new patients at all or have a lengthy wait time
 47 for obtaining an appointment that makes it impossible to see them in a timely manner. Wait time
 48 requirements could help address these issues. The AMA also urged CMS to consider additional
 49 tools to measure compliance beyond insurer attestation, including audits, secret shopper programs,
 50 and patient surveys.¹³

1 SALE OF HEALTH INSURANCE ACROSS STATE LINES

2
 3 The issue of permitting the sale of health insurance across state lines has been debated by the
 4 House of Delegates several times over the years, with proponents arguing that this would spur
 5 competition, choice, and affordability and others maintaining that any such allowances could
 6 motivate insurers to incorporate in states with less insurance regulation, putting important patient
 7 and provider protections at risk. Under AMA Policy H-180.946, established in 2017, the AMA
 8 would support the sale of health insurance across state lines, including multistate compacts, when
 9 patient and provider protection laws are consistent with and enforceable under the laws of the state
 10 in which the patient resides. These protections include not weakening any state’s laws or
 11 regulations involving network adequacy and transparency; fair contracting and claims handling;
 12 prompt payment for physicians; regulation of unfair health insurance market products and
 13 activities; rating and underwriting rules; grievance and appeals procedures; and fraud. The
 14 sentiment of AMA policy is that patients purchasing an out-of-state policy should retain the right to
 15 bring a claim against an insurer in a state court in the state in which the patient resides.

16
 17 Because a state’s insurance regulator cannot enforce another state’s laws or regulate beyond its
 18 borders, consumer protections and other regulations must be clearly defined when interstate health
 19 insurance sales are permitted. It is unclear whether insurers would even be interested in selling
 20 products in new markets across state lines where other carriers are already competing. When
 21 interstate health insurance sales were debated at the federal level in 2017, a handful of states had
 22 laws allowing such sales; however, out-of-state issuers were not drawn to these markets, primarily
 23 due to the costs and other challenges associated with developing provider networks in another state.
 24 Some stakeholders, including the American Academy of Actuaries and the National Association of
 25 Insurance Commissioners, have cautioned that interstate sales will neither increase competition nor
 26 decrease premium pricing but could have unintended consequences related to consumer protections
 27 and adverse selection.¹⁴

28
 29 ADDITIONAL POLICIES IMPACTING THE MARKETPLACE IN 2023

30
 31 *Extension of Enhanced Premium Tax Credit Subsidies:* The Inflation Reduction Act, signed into
 32 law in August 2022, extends through 2025 the enhanced premium tax credits that were made
 33 available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable
 34 and refundable credit, which the AMA supports, reduces the premium contribution for families
 35 with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides
 36 subsidies to 90 percent of consumers selecting marketplace plans. Partly as a result, enrollment in
 37 marketplace plans has reached record highs, surpassing 16 million during the open enrollment
 38 period that ran until mid-January 2023 for most exchanges.¹⁵ Additionally, the enhanced subsidies
 39 significantly increase affordability of marketplace plans and will improve the stability of the
 40 exchange market if healthier people enroll.¹⁶

41
 42 *Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage:* The
 43 Consolidated Appropriations Act of 2023 decoupled the Medicaid continuous enrollment
 44 requirement from the public health emergency (PHE) end date and permitted state eligibility
 45 redeterminations of Medicaid/CHIP enrollees to begin as early as March 2023. Although it is not
 46 yet known how many individuals will be disenrolled as states undertake these mass
 47 redeterminations, major disruptions in coverage are anticipated and many people could become
 48 uninsured. Importantly, CMS established a SEP for consumers losing Medicaid/CHIP coverage due
 49 to the unwinding of the continuous enrollment requirement. This SEP, which allows individuals
 50 and families to enroll in marketplace plans, if eligible, outside of the annual open enrollment
 51 period, runs between March 31, 2023 and July 31, 2024 and presents a significant enrollment

1 opportunity for the exchanges.¹⁷ The Council addressed the mass redeterminations and strategies
2 for preventing coverage losses in [Council Report 03-A-22](#).

3
4 *Fixing the “Family Glitch:”* The AMA long supported fixing the “family glitch” and was
5 accomplished this year by regulations allowing family members of workers offered affordable self-
6 only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it was
7 anticipated that nearly one million Americans would see their coverage become more affordable.¹⁸

8
9 *Requiring Standardized Plan Options:* To address “choice overload” and increase transparency, in
10 2023, CMS began requiring issuers offering QHPs on HealthCare.gov to offer standardized benefit
11 plans for every product, metal level, and geographic area. In comment letters to CMS, the AMA
12 has supported this change which will help highlight clear and meaningful differences between
13 plans, simplify consumer choice, and improve the plan selection process.¹⁹

14 15 AMA POLICY

16
17 As previously noted, Council on Medical Service Report 3-A-18 established Policy H-165.825,
18 which added to the AMA’s strong body of policy on marketplace competition and health plan
19 choice. Policy H-165.839 outlines principles for the operation of health insurance exchanges,
20 including that: health insurance exchanges should maximize health plan choice for individuals and
21 families purchasing coverage; health plans participating in the exchange should provide an array of
22 choices, in terms of benefits covered, cost-sharing levels, and other features; and federal authority
23 or oversight of health insurance exchanges must respect the role of state insurance commissioners
24 with regard to ensuring protections for patients and physicians. Additionally, this policy supports
25 using the open marketplace model for any health insurance exchange to increase competition and
26 maximize patient choice of health plans.

27
28 Policy H-165.838 supports health reform initiatives that are consistent with long-standing AMA
29 policies on pluralism, freedom of choice, freedom of practice, and universal access for patients.
30 This policy also states that insurance coverage options offered in a health insurance exchange be
31 self-supporting; have uniform solvency requirements; not receive special advantages from
32 government subsidies; include payment rates established through meaningful negotiations and
33 contracts; not require provider participation; and not restrict enrollees’ access to out-of-network
34 physicians. Support for fixing the ACA’s “family glitch” is addressed by Policy H-165.828, which
35 also supports efforts to ensure clear and meaningful differences between plans offered on health
36 insurance exchanges.

37
38 Principles to guide in the evaluation of the adequacy of health insurance coverage options are
39 outlined in Policy H-165.846, including that: any insurance pool or similar structure designed to
40 enable access to age-appropriate health insurance coverage must include a wide variety of coverage
41 options from which to choose; existing federal guidelines regarding types of health insurance
42 coverage should be used as a reference when considering if a given plan would provide meaningful
43 coverage; and mechanisms must be in place to educate patients and assist them in making informed
44 choices. This policy also opposes waivers of essential health benefits (EHB) requirements that lead
45 to the elimination of EHB categories and their associated protections. Policy H-165.865 states that
46 in order to qualify for a tax credit for the purchase of individual health insurance, the health
47 insurance purchased must provide coverage for hospital care, surgical and medical care, and
48 catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the U.S. Code.

49
50 Network adequacy is addressed in Policy H-285.908, which supports state regulators as the primary
51 enforcer of network adequacy requirements. This policy supports requiring health insurers to

1 submit and make publicly available, at least quarterly, reports to state regulators that provide data
 2 on several measures of network adequacy. Policy H-180.946 supports the selling of insurance
 3 across state lines that ensure that certain patient and provider protection laws are consistent with
 4 and enforceable under the laws of the state in which the patient resides. Additionally, Policy
 5 H-180.946 states that patients purchasing an out-of-state policy should retain the right to bring a
 6 claim in a state court in the state in which the patient resides.

7
 8 Policy H-165.856 supports greater national uniformity of market regulation across health insurance
 9 markets, geographic location, or type of health plan. Under this policy, state variation in market
 10 regulation is permissible so long as states demonstrate that departures from national regulations
 11 would not drive up the number of uninsured, and so long as variations do not hamper the
 12 development of multi-state group purchasing alliances or create adverse selection. Under Policy
 13 D-165.971, the AMA will support an association health plan that safeguards state and federal
 14 patient protection laws, including those state regulations regarding fiscal soundness and prompt
 15 payment. Policy D-180.986 encourages local, state, and federal regulatory authorities to
 16 aggressively pursue action against “sham” health insurers.

17
 18 Policy H-180.947 opposes consolidation in the health insurance industry that may result in
 19 anticompetitive markets. Antitrust reform is an AMA priority under Policy D-383.990, which
 20 directs the AMA to continue to: aggressively advocate for a level playing field for negotiations
 21 between physicians and health insurers; advocate to the Federal Trade Commission and
 22 Department of Justice for more flexible and fair treatment of physicians and for greater scrutiny for
 23 insurers; continue to develop and publish objective evidence of the dominance of health insurers
 24 through its study, *Competition in Health Insurance*; and identify consequences of the concentration
 25 of market power by health plans.

26
 27 DISCUSSION

28
 29 Insurer participation in the ACA marketplace has increased for five consecutive years, although a
 30 smaller increase was seen in 2023. Additionally, record numbers of individuals have signed up for
 31 coverage in the exchanges, which seem to be functioning well. Enrollment is likely being
 32 influenced this year by 1) the Inflation Reduction Act’s extension of enhanced premium tax credit
 33 subsidies for marketplace plans, through 2025, and 2) the disenrollment of individuals no longer
 34 eligible for Medicaid/CHIP, some of whom may be eligible for subsidized ACA plans. Still, the
 35 Council recognizes that insurer participation in the marketplace remains lower today than in 2015,
 36 when it was at its highest, and the share of plans offered by large insurers has been steadily
 37 growing in recent years. Additionally, many insurer exchange markets remain highly concentrated,
 38 as evidenced by data compiled in the AMA’s most recent edition of *Competition in Health
 39 Insurance: A Comprehensive Study of U.S. Markets*. Importantly, health insurance markets are
 40 local; across states, there is significant variation in the number of insurers and plans offered in
 41 ACA exchanges and, within states, there may be differences in insurer participation in rural and
 42 urban regions. The Council shares the sentiment of many physicians that insufficient competition
 43 in the ACA marketplace remains concerning in many areas.

44
 45 The Council also recognizes that the AMA has been a longstanding advocate for health insurance
 46 coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and
 47 universal access for patients. The [AMA’s plan to cover the uninsured](#), updated annually with new
 48 policy and metrics on the uninsured, lays out key calls for action to not only maintain, but build
 49 upon, the coverage gains that have been achieved under the ACA. This plan guides ongoing AMA
 50 federal and state advocacy on health reform policy priorities. Importantly, increasing insurer
 51 competition, maximizing health plan choice, and strengthening and ensuring the sustainability of

1 the ACA marketplace remain key AMA priorities. The Council has presented several reports in
2 recent years to establish and update AMA policy on these issues, including:

- 3
- 4 • [Council on Medical Service Report 4-I-17](#), Health Insurance Affordability: Essential
5 Health Benefits and Subsidizing the Coverage of High-Risk Patients;
- 6 • [Council on Medical Service Report 3-A-18](#), Ensuring Marketplace Competition and Health
7 Plan Choice;
- 8 • [Council on Medical Service Report 2-A-18](#), Improving Affordability in the Health
9 Insurance Exchanges;
- 10 • [Council on Medical Service Report 2-A-19](#), Covering the Uninsured under the AMA
11 Proposal for Reform;
- 12 • [Council on Medical Service Report 1-Nov.-20](#), Options to Maximize Coverage under the
13 AMA Proposal for Reform; and
- 14 • [Council on Medical Service Report 3-Nov.-21](#), Covering the Remaining Uninsured.
- 15

16 Additionally, the Council highlights the following AMA policies addressing the issues raised in
17 Policy D-165.933 and exemplifying the AMA's strong support for insurer competition and health
18 plan choice:

- 19
- 20 • Policy H-165.825, which offers solutions to ensuring marketplace competition and health
21 plan choice;
- 22 • Policy H-165.839, which supports using the open marketplace model for any health
23 insurance exchange and states that exchanges should maximize health plan choice;
- 24 • Policy H-165.838, under which insurance coverage options offered in an exchange should
25 be self-supporting and have uniform solvency and other requirements;
- 26 • Policy H-165.846, which outlines principles to guide in the evaluation of health insurance
27 coverage options;
- 28 • Policy H-180.946, which supports the selling of insurance across state lines, including
29 multistate compacts, when patient and provider protection laws are consistent with and
30 enforceable under the laws of the state in which the patient resides;
- 31 • Policy H-165.856, which supports greater uniformity of market regulation across health
32 insurance markets, geographic location, or type of health plan; and
- 33 • Policy H-180.947, which opposes consolidation in the health insurance industry that may
34 result in anticompetitive markets.
- 35

36 CONCLUSION

37
38 During the development of this report, the Council did not identify gaps in existing AMA policy on
39 competition and choice and, therefore, makes no policy recommendations at this time. However,
40 the Council believes network adequacy, which is key to maintaining healthy competition and
41 choice in the exchanges, is an issue that remains problematic and is worthy of additional study.
42 Relatedly, the Council is concerned about the ability of patients to see certain physicians who are
43 listed by plans as in-network but for whom, in reality, access is limited. Accordingly, the Council
44 has begun looking at the need for stronger network adequacy standards for ACA, Medicare
45 Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

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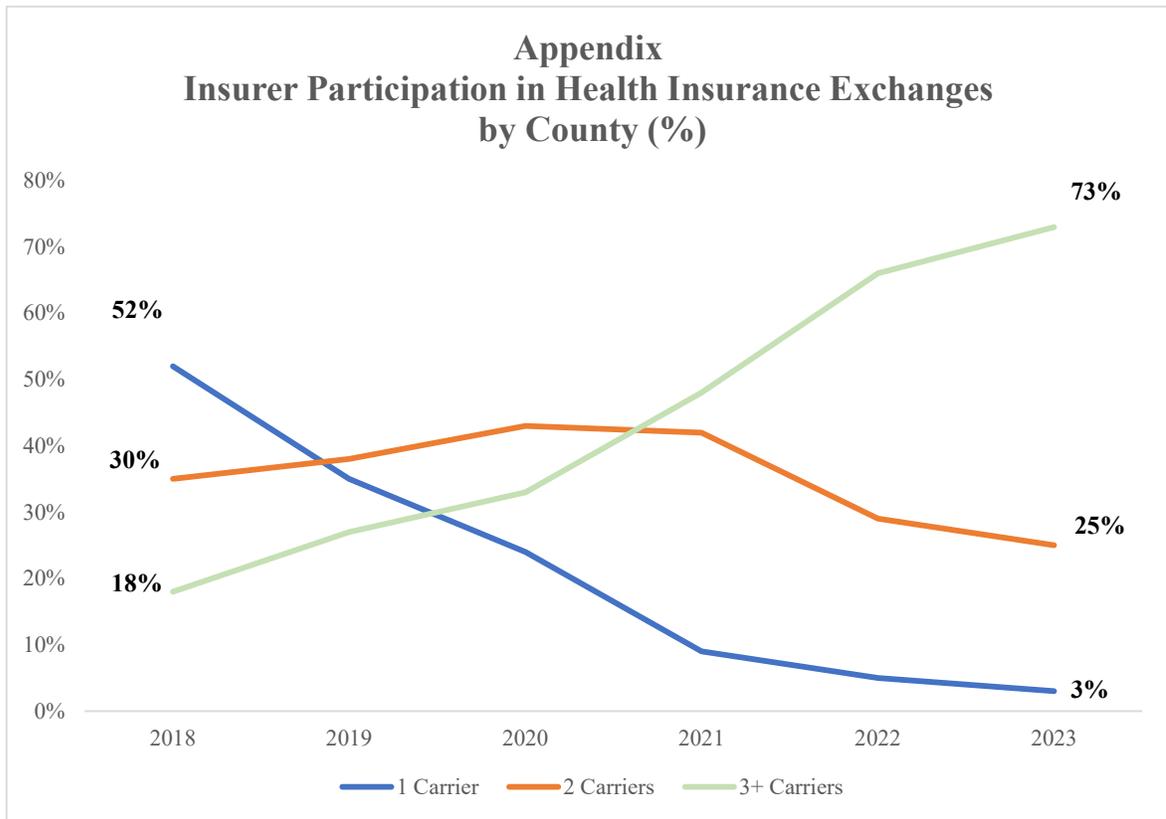
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Values may not add up to 100% due to rounding.