AMA
AMERICAN MEDICAL ASSOCIATION

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

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

Date: May 19, 2023

Subject: Handbook Addendum - Supplemental Business and Information

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

<u>Resolutions</u>

008 Study on the Criminalization of the Practice of Medicine
009 Racism - A Threat to Public Health
010 Advocating for Increased Support to Physicians in Family Planning and Fertility
011 Rights of the Developing Baby
012 Viability of the Newborn
013 Serial (Repeated) Sperm Donors
014 Redressing the Harms of Misusing Race in Medicine
015 Report Regarding the Criminalization of Providing Medical Care
111 Potential Negative Consequences of ACOs
112 Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs
113 Cost of Insulin
114 Physician and Trainee Literacy of Healthcare Costs
115 Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
116 Medicare Coverage of OTC Nicotine Replacement Therapy
225 Regulation of "Cool/Non-Menthol" Tobacco Products
226 Vision Qualifications for Driver's License
227 Reimbursement for Postpartum Depression Prevention
228 Reducing Stigma for Treatment of Substance Use Disorder
229 Firearm Regulation for Persons Charged with or Convicted of a Violent Offense
230 Address Disproportionate Sentencing for Drug Offenses
231 Equitable Interpreter Services and Fair Reimbursement
232 Supervised Injection Facilities (SIFs) Allowed by Federal Law
233 Dobbs - EMTALA Medical Emergency
234 Medicare Physician Fee Schedule Updates and Grassroots Campaign
235 EMS as an Essential Service
236 AMA Support for Nutrition Research
237 Prohibiting Covenants Not-To-Compete in Physician Contracts
238 Eliminate Mandatory Medicare Budget Cuts
239 Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians
240 Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication
241 Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents
242 Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

243 Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony
244 Recidivism
245 Biosimilar/Interchangeable Terminology
246 Modification of CMS Interpretation of Stark Law
247 Assessing the Potentially Dangerous Intersection Between AI and Misinformation
248 Supervised Consumption Sites
249 Restrictions on Social Media Promotion of Drugs
250 Medicare Budget Neutrality
251 Federal Government Oversight of Augmented Intelligence
252 Strengthening Patient Privacy
253 Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)
254 Eliminating the Party Statement Exception in Quality Assurance Proceedings
255 Correctional Medicine
315 Prohibit Discriminatory ERAS® Filters In NRMP Match
316 Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges
317 Supporting Childcare for Medical Residents
318 Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions
319 Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
320 Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession
321 Corporate Compliance Consolidation
322 Disclosure of Compliance issues and Creating a National Database of Joint Leadership
425 Examining Policing Through a Public Health Lens
426 Accurate Abortion Reporting with Demographics by the Center for Disease Control
427 Minimizing the Influence of Social Media on Gun Violence
428 Mattress Safety in the Hospital Setting
429 Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System
430 Teens and Social Media
431 Qualified Immunity Reform
517 Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States
518 Defending NIH funding of Animal Model Research From Legal Challenges
519 Rescheduling or Descheduling Testosterone
520 Supporting Access to At-Home Injectable Contraceptives
521 Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs
522 Approval Authority of the FDA
523 Reducing Youth Abuse of Dextromethorphan
524 Ensuring Access to Reproductive Health Services Medications
606 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
607 Enabling Sections of the American Medical Association
608 Supporting Carbon Offset Programs for Travel for AMA Conferences
710 Protect Patients with Medical Debt Burden
711 Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
712 Medical Bankruptcy – A Unique Feature in the USA
713 Redesigning the Medicare Hospice Benefit
714 Improving Hospice Program Integrity
715 Published Metrics for Hospitals and Hospital Systems
716 Transparency and Accountability of Hospitals and Hospital Systems
717 Improving Patient Access to Supplemental Oxygen Therapies
718 Insurance Coverage of FDA Approved Medications and Devices
719 Care Partner Access to Medical Records

720 Prior Authorization Costs, AMA Update to CMS
721 Use of Artificial Intelligence for Prior Authorization
722 Expanding Protections of End-Of-Life Care

Referral Changes:

Resolution 504, Regulating Misleading AI Generated Advice to Patients, has been reassigned to Reference Committee B and is now Resolution 256.

Resolution 506, Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development, has been reassigned to Reference Committee F and is now Resolution 609.

In addition, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the June 2022 and November 2022 House of Delegates Meetings will be posted on the June 2023 Annual Meeting website.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-23)

Introduced by: American Society of Addiction Medicine

Subject: Study on the Criminalization of the Practice of Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The American Medical Association has policy opposing the attempted criminalization
2 of health care decision-making (H-160.946, *The Criminalization of Health Care Decision*
3 *Making*); and

4 Whereas, US District Judge Matthew Kacsmaryk's ruling that the US Food and Drug
5 Administration's (FDA's) approval of Mifepristone was to be suspended was based on junk
6 science and political ideology and threatened the integrity of the FDA itself; and
7
8 Whereas, Florida passed a state statute in 2011, *Florida's Firearm Owner's Privacy Act*, which
9 was a gag law restricting doctors from discussing firearm ownership and firearm safety with
10 patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the
11 four provisions violated the First Amendment rights of physicians; and
12
13 Whereas, At least 30 states have introduced or passed laws that restrict gender-affirming
14 services for minors and/or adults, often resulting in professional or criminal penalties for
15 physicians, parents, and others involved in providing the care; and
16
17 Whereas, At least 13 states have made providing abortions illegal with targeted regulation of
18 abortion providers (TRAP) laws that single out physicians who provide abortion care and are
19 more burdensome than those imposed on physicians who provide comparable types of care.
20 These laws do not increase patient safety and are contrary to evidence-based medicine; and
21
22 Whereas, The Department of Justice (DOJ) has established the Appalachian Regional
23 Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force,
24 specifically to swiftly and effectively prosecute medical professionals[1]; and
25
26 Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data
27 analytics to identify and prosecute individual physicians[2]; and
28
29 Whereas, The DOJ has used non-scientific "red flag" data to, in part, determine physicians to
30 target for prosecution. Among these data are whether patients have traveled more than 30 miles
31 if in an urban area or 120 miles if in a rural area to obtain treatment[3]; and
32
33 Whereas, Certain specialties are likely to include individual physicians who may find themselves
34 under investigation as a result of successful business practices, a high volume of controlled
35 substance prescribing, or for being one of a few specialists in the area and therefore having
36 patients from a wide catchment area; therefore be it

1 RESOLVED, That our American Medical Association study the rapidly changing environment in
2 which the practice of medicine has been criminalized, the degree to which such criminalization
3 is based or not based upon valid scientific findings, as well as the degree to which this is
4 altering the actual practice of medicine due to physician concerns and personal risk
5 assessments, reporting back to the HOD no later than the June, 2024 Annual Meeting.
6 (Directive to Take Action)

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

Received: 5/8/23

REFERENCES

1. https://www.justice.gov/criminal-fraud/arpo-strike-force
2. https://www.americanbar.org/news/abanews/aba-news-archives/2021/12/washington-health-law-summit/
3. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-23)

Introduced by: Minnesota

Subject: Racism - A Threat to Public Health

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Racism is a public health crisis - a crisis rooted in the institutional, structural, and
2 systemic barriers that continue to affect Black, Indigenous and other communities of color; and
3
4 Whereas, Racism may be intentional or unintentional; operates at many levels within society,
5 and is a barrier to health equity; and
6
7 Whereas, Racism is a social driver of health (like housing, education, and employment) that has
8 a deep impact on the health status of children, adolescents, and adults within marginalized
9 communities; and
10
11 Whereas, Policymakers and our healthcare community need to work to address racism and its
12 barriers, and do what is needed to eliminate the health inequities that disproportionately affect
13 Black, Indigenous and other communities of color; and
14
15 Whereas, Standardizing how the various social drivers of health are recorded in a clinical
16 encounter is needed in order to improve clinical practice, research, and policy; and
17
18 Whereas, Existing codes in the International Classification of Diseases (ICD) system do not
19 encompass some of the most important social drivers of health, including racism; and
20
21 Whereas, Documenting instances where experiencing racism could be a causal factor in a
22 health condition is important; and
23
24 Whereas, Examples of a patient experiencing racism include (1) a patient who presents with
25 chronic stress and high-blood pressure due to exposure to racist abuse or discrimination; and
26 (2) a patient who has experienced frequent racist encounters and is now presenting in clinic with
27 low-grade inflammation; therefore be it
28
29 RESOLVED, That our American Medical Association advocate for the creation of an
30 International Classification of Diseases (ICD) code for patients presenting with conditions
31 related to experiencing racism, a code that will provide physicians with the tools necessary to
32 address racism within the clinical encounter, and capture the data needed to provide more
33 effective patient care. (Directive to Take Action)

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

Received: 5/3/23

REFERENCES

1. Maria Trent, Danielle G. Dooley, Jacqueline Dougé, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE, Robert M. Cavanaugh, Amy E. Lacroix, Jonathon Fanburg, Maria H. Rahmandar, Laurie L. Hornberger, Marcie B. Schneider, Sophia Yen, Lance Alix Chilton, Andrea E. Green, Kimberley Jo Dilley, Juan Raul Gutierrez, James H. Duffee, Virginia A. Keane, Scott Daniel Krugman, Carla Dawn McKelvey, Julie Michelle Linton, Jacqueline Lee Nelson, Gerri Mattson, Cora C. Breuner, Elizabeth M. Alderman, Laura K. Grubb, Janet Lee, Makia E. Powers, Maria H. Rahmandar, Krishna K. Upadhya, Stephenie B. Wallace; The Impact of Racism on Child and Adolescent Health. *Pediatrics* August 2019; 144 (2): e20191765. 10.1542/peds.2019-1765
2. Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. Annu Rev Public Health. 2019 Apr 1;40:105-125. doi: 10.1146/annurev-publhealth-040218-043750. Epub 2019 Feb 2. PMID: 30601726; PMCID: PMC6532402.
3. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: a systematic review and meta-analysis. *PLoS ONE*. 2015;10(9): e0138511.
4. Fritz Handerer, Peter Kinderman, and Sara Tai. The Lancet, Psychiatry. The need for improved coding to document the social determinants of health. August, 2021DOI:https://doi.org/10.1016/S2215-0366(21)00208-X

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-23)

Introduced by: Women Physicians Section

Subject: Advocating for Increased Support to Physicians in Family Planning and Fertility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, One in four female physicians will suffer from infertility,[1] well above the estimated
2 incidence (9%–18%) in the U.S. general population[1]; and
3
4 Whereas, Physician fertility and family planning, however, are rarely discussed as part of formal
5 education during medical school, residency, or subsequent practice; and
6
7 Whereas, Among female physicians, infertility, high-risk pregnancies, and miscarriages have
8 been associated with higher rates of burnout—as a cause, a consequence, or both[2]; and
9
10 Whereas, Evidence suggests female physicians are at higher risk of burnout than their male
11 colleagues due to multiple factors, including work–life integration and gender bias[2]; and
12
13 Whereas, The lack of physician education on the risks and consequences of infertility
14 exacerbates its potential emotional, physical, and financial impacts. Individuals/couples seeking
15 fertility preservation or treatment for infertility may experience emotional distress, which may
16 manifest as anxiety, guilt, loss of hope, loss of control, bereavement, and stigmatization[3,4];
17 therefore be it
18
19 RESOLVED, That our American Medical Association advocate for academic and employed
20 physician practices to contract with insurance providers who provide infertility coverage that
21 defrays the steep costs for fertility treatments (Directive to Take Action); and be it further
22
23 RESOLVED, That our AMA work with other key stakeholders to encourage full support of
24 physicians desiring to have families to allow for flexible work policies and clinical coverage for
25 those undergoing fertility treatments. (Directive to Take Action)

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

Received: 5/5/23

REFERENCES

1. Chandra A, Martinez GM, Mosher WD, Abma JC, Jones J. Fertility, family planning, and reproductive health of U.S. women: Data from the 2002 National Survey of Family Growth. Vital Health Stat 23(25). 2005. Washington, DC: National Center for Health Statistics; https://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf
2. Templeton K, Bernstein CA, Sukhera J, et al. Gender-based differences in burnout: Issues faced by women physicians. NAM Perspectives. 2019. Washington, DC: National Academy of Medicine; https://doi.org/10.31478/201905a.
3. Cousineau TM, Domar AD. Psychological impact of infertility. Best Pract Res Clin Obstet Gynaecol. 2007;21:293–308.
4. Patel A, Sharma PSVN, Kumar P. "In cycles of dreams, despair, and desperation": Research perspectives on infertility specific distress in patients undergoing fertility treatments. J Hum Reprod Sci. 2018;11:320–328.
5. Marshall, Ariela L. MD; Arora, Vineet M. MD, MAPP; Salles, Arghavan MD, PhD. Physician Fertility: A Call to Action. Academic Medicine 95(5):p 679-681, May 2020. | DOI: 10.1097/ACM.0000000000003079
6. Konopasek L, Bernstein C. Inventory of elements of your institutional well-being plan. https://www.acgme.org/Portals/0/PDFs/Webinars/DIOWell-BeingInventoryACGME2016.pdf?ver=2018-09-17-091328-113

RELEVANT AMA POLICY

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;

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Rights of the Developing Baby

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, At the moment of conception a new genetically unique fetus apart from pregnant
2 woman who is carrying it is created; and
3
4 Whereas, That developing fetus has a total dependency of the mother carrying that fetus; and
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6 Whereas, That mother carrying the fetus, has according to AMA policy passed in I-2022(1) total
7 autonomy over her body; and
8
9 Whereas, At I-2022 affirmed abortion(1) as a human right; and
10
11 Whereas, The point of viability is to be determined by her doctor(s); and
12
13 Whereas, At the point of viability, the doctor(s) has two patients to care for; and
14
15 Whereas, Up until the point of viability, there is no statement of fetal/pre-natal rights in the AMA
16 Code of Ethics (or the AOA Code of Ethics); therefore be it
17
18 RESOLVED, That our American Medical Association's Council of Judicial and Ethical Affairs
19 (CEJA) address the rights of the viable fetus in a report to be delivered no later than the 2024
20 Annual meeting. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. Report 4 of the Board of Trustees (I-22) Preserving Access to Reproductive Health Services

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and

civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993
1. The AMA reaffirms existing policy that:
(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.
2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.
Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Viability of the Newborn

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, At the 2022 Interim meeting a woman's right to abortion was affirmed; and
2
3 Whereas, In that affirmation was a qualifier statement[1] that at the end of pregnancy the only
4 reason for an abortion is the endangerment of the life of the mother or severe fetal abnormalities
5 incompatible with life; and
6
7 Whereas, Current advanced neonatal care has lowered the viability of the newborn to
8 approximately 22 weeks gestation; and
9
10 Whereas, In that qualifier statement[1] there was no mention of care for a potentially viable
11 newborn; therefore be it
12
13 RESOLVED, That our American Medical Association advocate for availability of the highest
14 standard of neonatal care to aborted fetus born alive at a gestational age of viability. (Directive
15 to Take Action)

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

Received: 5/9/23

REFERENCES

1. Report 4 of the Board of Trustees (I-22) Preserving Access to Reproductive Health Services

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and

physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
Citation: Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22;

Right to Privacy in Termination of Pregnancy H-5.993
1. The AMA reaffirms existing policy that:
(a) abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice; and (b) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.
2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.
Citation: Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-23)

Introduced by: Illinois

Subject: Serial (Repeated) Sperm Donors

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, Some individuals have become multiple sperm donors; and
2
3 Whereas, The female sperm recipient may not be aware that their sperm donor has made
4 multiple donations, and with the continued escalation of DNA and gene testing, the potential for
5 many unknown half cousins or half siblings or relatives is escalating; and
6
7 Whereas, The discovery of the existence of unknown relatives may lead to family and legal
8 concerns unexpectantly; therefore be it
9
10 RESOLVED, That our American Medical Association work with other relevant national medical
11 specialty societies to study the further elaboration of potential risks associated with allowing
12 sperm from a single donor to be used to conceive children by multiple recipients and make
13 recommendations for additional policies to minimize these risks. (Directive to Take Action)

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

Received: 5/5/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Redressing the Harms of Misusing Race in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Pulmonary function tests (PFTs), also known as spirometry, are the standard of care for diagnosing obstructive and restrictive lung diseases such as asthma, emphysema, and interstitial lung disease[1]; and

Whereas, Differences in population averages for PFT values by race and socioeconomic status have long been documented and were used to justify and uphold slavery and structural racism in the United States in the 19th century, to deny workers' compensation claims for Welsh vs. English white miners in the United Kingdom in the early 20th century, and to deny workers' compensation claims for Black asbestos workers in Baltimore in a landmark 1999 case[2–5]; and

Whereas, Differences in population averages for PFT values by race may be explained by racially segregated exposure to environmental toxins, adverse working conditions, poor air quality, and worse access to health care — all of which impact lung health and disease progression[6–12] — yet widely used PFT reference values based on the National Health and Nutrition Survey (NHANES) have only included a "race adjustment" without accounting for any other relevant factors[13]; and

Whereas, The *AMA Guides to the Evaluation of Permanent Impairment* has been published for over 50 years and is the main guiding document for workers' compensation evaluations[14,15]; and

Whereas, Chapter 5 of the *AMA Guides* 6th edition states that "The [American Thoracic Society] Task Force for Interpretation of Pulmonary Function recommends an adjustment on a population basis for predicted lung function in Blacks," motivating clinicians to provide differential care by race[15]; and

Whereas, Chapter 5 of the *AMA Guides* 6th edition states that "Reliable population data are not yet available for other ethnic groups, such as Hispanics, Native Americans, and Asians. For these ethnic groups, the values for North American whites may be used," thereby motivating clinicians to use a reference standard derived only from white populations for a broad array of non-white populations[15]; and

Whereas, The American Thoracic Society, with endorsement from the European Respiratory Society, recently released new recommendations which state that "PFT laboratories should adopt a race-neutral approach to PFT interpretation by reporting and interpreting results using average reference equations" such as the Global Lung Initiative (GLI) aggregated equation, rather than using race-based algorithms[16,17]; and

Whereas, Race is a profoundly imprecise proxy for biological characteristics and should be instead characterized as a sociopolitical construct, in accordance with AMA-RFS and AMA policies (350.003R, H-65.953, D-350.981); and

Whereas, The economic consequences of using of race to deny workers' compensation to Black individuals is a problematic intersection of the medical field with *racial capitalism* — the "centrality of race in structuring social and labor hierarchies in capitalist economies"[18]; and

Whereas, The misuse of race in clinical algorithms is arguably a civil rights violation[19]; and

Whereas, Other race-based algorithms are actively being or have already been litigated, including a landmark lawsuit recently settled by hundreds of Black former National Football League players who were denied workers' compensation due to a race-normed cognitive testing algorithm, and pending lawsuits related to the now-defunct race-based estimated glomerular filtration rate (eGFR) equations[20–24]; and

Whereas, Our American Medical Association recognizes the public health threats of racism (H-65.952), advocates against the use of racial essentialism in medicine and clinical research (D-350.981, H-65.953), and recommends structural and cultural changes to prevent and address racism in healthcare (H-65.951); and

Whereas, Reparative approaches to address the disparate harms caused to patients by structural racism embedded in health care delivery are already being investigated and implemented at the health system, city, state, and national levels,[25-37] including federal inquiries from the House Ways & Means Committee and Agency for Healthcare Research & Quality,[32-34] proposed reforms to Section 1557 of the Affordable Care Act which prohibit the use of discriminatory clinical algorithms,[35] a "Blueprint for an AI Bill of Rights" from the Office for Science and Technology Policy,[36] and a new "time back" mandate from the Organ Procurement and Transplantation Network to restructure kidney transplant waiting lists to redress harms caused by race-based eGFR equations[37]; and

Whereas, Actively ongoing litigation, regulatory agency initiatives, and policymaking to address racism in clinical algorithms will continue to require input from our AMA within the next 6 months; therefore be it

RESOLVED, That our American Medical Association recognize the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field (New HOD Policy); and be it further

RESOLVED, That our AMA will revise the *AMA Guides to the Evaluation of Permanent Impairment*, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA support and promote racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. (New HOD Policy)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Racial Essentialism in Medicine D-350.981

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

Citation: Res. 10, I-20;

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

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

Citation: Res. 11, I-20;

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: 015
(A-23)

Introduced by: New York

Subject: Report Regarding the Criminalization of Providing Medical Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, The American Medical Association has policy opposing the attempted criminalization
2 of health care decision-making (H-160.946, *The Criminalization of Health Care Decision*
3 *Making*); and
4
5 Whereas, Physicians and other care providers have been criminally charged for medical errors
6 such as mistaking a dialysis catheter for a feeding tube in NY, mistakenly giving an excessive
7 dose of penicillin to a newborn in Colorado, an error in preparation of a chemotherapy solution
8 for a child in Ohio, mistakenly giving an anesthetic to a teenage patient in Wisconsin[1], and
9 errors in the medical record in Illinois[2]; and
10
11 Whereas, Florida passed a state statute in 2011, Florida's Firearm Owner's Privacy Act, which
12 was a gag law restricting doctors from discussing firearm ownership and firearm safety with
13 patients who have a firearm-related injury. In 2017 the Eleventh Circuit found that three of the
14 four provisions violated the First Amendment rights of physicians; and
15
16 Whereas, At least other 30 states have introduced or passed laws that have restricts gender-
17 affirming services for minors and/or adults, often resulting in professional or criminal penalties
18 for physicians, parents, and others involved in providing the care; and
19
20 Whereas, At least 13 states have made providing abortions illegal with Targeted regulation of
21 abortion providers (TRAP) laws that single out physicians who provide abortion care and are
22 more burdensome than those imposed on physicians who provide comparable types of care.
23 These laws do not increase patient safety and are contrary to evidence-based medicine; and
24
25 Whereas, The U.S. Department of Justice (DOJ) has established the Appalachian Regional
26 Prescription Opioid Strike Force and the New England Prescription Opioid Strike Force,
27 specifically to swiftly and effectively prosecute medical professionals[3]; and
28
29 Whereas, The DOJ has created the National Rapid Response Strike Force, which uses data
30 analytics to identify and prosecute individual and corporate actors in healthcare fraud[4]; and
31
32 Whereas, The DOJ has used non-scientific “red flag” data to, in part, determine physicians to
33 target for prosecution. Among these data are whether patients have traveled more than 30 miles
34 if in an urban area or 120 miles if in a rural area to obtain treatment[5]; and
35
36 Whereas, Certain specialties are likely to include individual physicians who find themselves
37 being investigated simply for having a successful business model, or for prescribing a high
38 volume of FDA-approved medication, or for being one of few specialists in the area and
39 therefore having patients from a wide service area; therefore be it

1 RESOLVED, That our American Medical Association study the rapidly changing environment in
2 which the practice of medicine has been criminalized, the degree to which such criminalization
3 is based or not based upon valid scientific findings, as well as the degree to which this is
4 altering the actual practice of medicine due to physician concerns and personal risk
5 assessments, reporting back to the House of Delegates no later than the 2024 Annual meeting.
6 (Directive to Take Action)

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

Received: 5/10/23

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4. https://www.americanbar.org/news/abanews/aba-news-archives/2021/12/washington-health-law-summit/
5. Health Integrity LLC PLATO Pill Mill Doctor Provider Project

RELEVANT AMA POLICY

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
Citation: Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Potential Negative Consequences of Accountable Care Organizations (ACOs)

Referred to: Reference Committee A

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1 Whereas, Centers for Medicare and Medicaid Services (CMS) has stated that one of its goals is
2 that all patients covered by traditional Medicare are to be in Accountable Care Organizations
3 (ACOs) by 2030[1]; and
4
5 Whereas, ACOs may cause financial risk for the physicians directly and/or indirectly; and
6
7 Whereas, The structure of ACOs demands that financial penalties to physicians be incurred if
8 the costs attributable to patient care exceed federally determined benchmarks. Without more
9 granular risk adjustment methodologies, there remains a risk of disincentivizing physicians from
10 taking care of patients with more complicated medical care needs; and
11
12 Whereas, ACO participation is logistically difficult or impossible for independent small or solo
13 practices; and
14
15 Whereas, ACOs create another expensive layer of bureaucratic burden contributing to burnout
16 and possibly impacting the patient-physician relationship; therefore be it
17
18 RESOLVED, That our American Medical Association advocate for the provision of health care
19 and reimbursement models that are in the best interest of patients and offer risk adjustment
20 methodologies to prevent financial penalty to the physician and other healthcare team members
21 who provide care for the sickest patients (Directive to Take Action); and be it further
22
23 RESOLVED, That our AMA oppose capitation care healthcare systems, such as ACOs, when
24 such systems place physicians and other healthcare team members at financial risk for the
25 overall healthcare costs of their patients, including costs attributable to care provided by other
26 entities (New HOD Policy); and be it further
27
28 RESOLVED, That our AMA advocate for flexible pathways for small practice participation in
29 ACOs that greatly mitigate ACO participation-related bureaucratic burdens and help protect
30 small practices from large financial penalties otherwise assigned to large health systems for
31 cost overages (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA oppose CMS mandates that require Medicare beneficiaries to enroll
34 in ACOs (New HOD Policy); and be it further
35
36 RESOLVED, That our AMA oppose the expansion of capitation care systems, such as ACOs,
37 as a means of providing coverage and services for all Medicare enrollees. (New HOD Policy)

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

Received: 5/10/23

REFERENCES

1. CMMI.CMS.gov Strategic Direction White Paper 2022
2. Medicare Payment Advisory Commission (MedPAC) Meeting pg 39-40 April 4, 2013. (MedPAC is an independent congressional agency established by the Balance Budget Act of 1997 to advise the US Congress on issues affecting the Medicare program)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-23)

Introduced by: American College of Chest Physicians

Subject: Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

Referred to: Reference Committee A

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1 Whereas, Lung cancer is the leading cause of cancer deaths in the United States, accounting
2 for approximately 22% of all cancer deaths[1]; and
3
4 Whereas, Detecting lung cancer in its early stages is crucial for effective treatment, but only
5 22% of lung cancer cases are diagnosed early; and
6
7 Whereas, Low-dose computed tomography (LDCT) screening has been shown to reduce lung
8 cancer mortality by up to 20% among high-risk populations[2]; and
9
10 Whereas, The U.S. Preventive Services Task Force has recommended LDCT screening for
11 high-risk populations; and
12
13 Whereas, Studies have shown that uptake of screening is highly dependent on coverage
14 eligibility and no-cost access to preventative measures, screening-eligible Black adults are
15 nearly twice as likely to rely on Medicaid, which may not cover LDCT screening, exacerbating
16 long-standing inequities in lung cancer outcomes[3]; and
17
18 Whereas, The American Medical Association has policy recommending coverage of LDCT
19 scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a
20 required covered benefit (AMA policy H-185.936); and
21
22 Whereas, The AMA also encourages state medical associations to provide ongoing feedback
23 regarding barriers to access to their state's Medicaid access monitoring review plan (AMA policy
24 H-290.965); and
25
26 Whereas, Many states, including those with Medicaid expansion and traditional Medicaid
27 programs, have created barriers to lung cancer screening such as pre-authorization and co-
28 pays; therefore be it
29
30 RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid
31 Services (CMS) to encourage and insist that all states, both Medicaid expansion and traditional
32 Medicaid, remove barriers to care for lung cancer screening, including but not limited to pre-
33 authorization and co-pay requirements (Directive to Take Action); and be it further
34
35 RESOLVED, That our AMA, and their state medical associations, work with the Centers for
36 Medicare & Medicaid Services (CMS) and State Medicaid Managed Care Organizations to
37 develop and implement strategies to improve access to LDCT screening for high-risk
38 populations in Medicaid programs (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate for increased funding for research and education to
2 further increase awareness and uptake of LDCT screening for lung cancer among high-risk
3 populations (Directive to Take Action); and be it further
4
5 RESOLVED, That our AMA urge state medical associations to work with their respective
6 Medicaid programs to ensure that these programs comply with the AMA's policy on LDCT
7 screening for high-risk populations. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Siegel RL, Miller KD, Journal A. Cancer Statistics, 2019: A Cancer Journal for Clinicians. 2019; 69: 7-34.
2. The National Lung Cancer Screening Trial Team. Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening. New England Journal of Medicine, August 2011; 365(5): 396-409.
3. Lozier JW, Fedewa SA, Smith RA, Silvestri GA. Lung Cancer Screening Eligibility and Screening Patterns Among Black and White Adults in the United States. JAMA Netw Open. 2021 Oct 1;4(10):e2130350.

RELEVANT AMA POLICY

Lung Cancer Screening to be Considered Standard Care H-185.936
Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; and (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
Citation: Sub. Res. 114, A-14; Appended: Res. 418, A-22;

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-23)

Introduced by: Georgia

Subject: Cost of Insulin

Referred to: Reference Committee A

Whereas, There are approximately 30.3 million people in the United States with diabetes and about 1.5 million of those require insulin to survive; and

Whereas, Between 2012 and 2016 the price of insulin almost doubled with the average cost of insulin per patient in 2012 at $2,864 per year and in 2016 at $5,705; and

Whereas, The retail price for a 10ml vial of insulin is approximately $330 and some patients need six vials per month; and

Whereas, Americans pay ten times more on average for insulin than people in other developed countries; and

Whereas, A 2018 study found that a vial of insulin could be made for between $3 to $8; and

Whereas, 90% of insulin produced comes from three companies: Eli Lilly, Novo Nordisk, and Sanofi; and

Whereas, The three producers have patient assistance programs to help the uninsured but require a process that can take up to 60 days for review and approval, during which an insulin-dependent-diabetic could die; and

Whereas, The insured are at the mercy of the pharmacy benefit managers (PBMs) who require rebates to have their brand of insulin included in the insurance formulary thus driving up the cost of insulin and all other drugs; and

Whereas, Americans have been skipping doses of insulin, traveling across borders to Canada to purchase affordable insulin, even dying when they could not purchase it, and have medical expenditures 2.3 times higher because of the diagnosis; and

Whereas, COVID-19 is now triggering diabetes in patients who did not previously have it, and in one study COVID-19 survivors were 39% more likely to have a new diabetes diagnosis in the six months after infection; and

Whereas, In 2021 Novo Nordisk made $52 Billion in revenue and in 2020 Eli Lilly made $24 Billion, and Sanofi made $46 Billion; and

Whereas, On April 2, 2022, the House of Representatives passed the Affordable Insulin Now Act that would limit the cost of insulin to $35 a month for insured patients, but even $35 a vial times up to six or more vials of insulin a month could be unaffordable to the most fragile; and

1 Whereas, The estimated total economic cost of diabetes yearly is in excess of $300 billion;
2 therefore be it
3
4 RESOLVED, That our American Medical Association urge Congress to mandate complete
5 coverage of any insulin approved by the FDA (at $0 cost) for any patient, insured or uninsured,
6 who presents to the pharmacy and bypassing all PBMs and disallowing any rebates. (Directive
7 to Take Action)

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

Received: 5/9/23

RELEVANT AMA POLICY

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.
Citation: CMS Rep. 07, A-18; Modified: Res. 118, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-23)

Introduced by: Illinois

Subject: Physician and Trainee Literacy of Healthcare Costs

Referred to: Reference Committee A

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1 Whereas, The cost of medical care continues to increase, now 18% of U.S. GDP[1,2]; and
2
3 Whereas, Meta-analyses estimate extraneous healthcare spending between $706-935 billion
4 USD, about 25% of total healthcare spending[3]; and
5
6 Whereas, Price transparency is an important aspect of a functioning market[4]; and
7
8 Whereas, Federal mandates to publish hospital chargemasters have largely been ignored[5]; and
9
10 Whereas, Federal mandates to publish health insurer billing data have yet to show market
11 adoption[6]; and
12
13 Whereas, Many physicians believe they have an obligation to address rising healthcare costs[7];
14 and
15
16 Whereas, Physician literacy on healthcare costs is an important component of informed
17 decision-making which may have a significant impact on future discussions of health system
18 reform; and
19
20 Whereas, Medical school accreditation does not require medical schools to teach healthcare
21 financing and the costs associated with care[8]; and
22
23 Whereas, Medical students are more price sensitive than their senior colleagues and interested
24 in considering a patient's financial health if given the appropriate information[9,10]; and
25
26 Whereas, Residency accreditation requires institutions to cover healthcare finance but not the
27 billing practices of local or any other healthcare organization[11]; and
28
29 Whereas, U.S. physicians are bad estimators of health costs[12,13]; and
30
31 Whereas, Physicians often guide patients to the best medical decision without accurate
32 estimations for cost[14]; and
33
34 Whereas, Patient decisions and health are impacted by whether they can afford the care
35 decided within the physician-patient relationship[15,16]; and
36
37 Whereas, Patients who have concerns about the affordability of their prescriptions may skip
38 doses, decrease doses, or not fill their prescription altogether[17]; and

Whereas, The physician-patient relationship is the ideal place for conversations regarding the cost of care and potential affordable alternatives; and

Whereas, New healthcare companies are being created to provide clarity in a variety of health services using information readily available[18,19]; and

Whereas, A northwestern Wisconsin medical group has called for radical healthcare reform through a series of recommendations, including suggesting that healthcare facilities should be required to list their prices[20]; and

Whereas, The Wisconsin Medical Society supports the promotion of healthcare cost transparency, including prices, true costs, Medicare and Medicaid payments for services, drugs, and treatments[21]; and

Whereas, The Australian Medical Association has developed a process for Informed Financial Consent between doctors and patients to encourage shared decision-making about the costs of medical treatment, physicians' fees, and healthcare benefits[22]; therefore be it

RESOLVED, That our American Medical Association endorse price transparency within all sectors of the healthcare market (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all physician employers, including hospitals, to allow their healthcare professionals access to accurate and easily understandable costs of any laboratory test, procedure, medication, medical supply, or any other cost related to medical care within and outside their organization (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for all physician employers, including hospitals, to empower their healthcare professionals to incorporate discussions on healthcare costs during patient counseling (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for medical education inclusive of price transparency, financial literacy, and the economics and financing of healthcare delivery (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Commission of Osteopathic College Accreditation (COCA), the Liaison Committee on Medical Education (LCME), the Accreditation Council on Graduate Medical Education (ACGME), and other relevant stakeholders, to include price transparency and healthcare financing in medical education as components of program accreditation (Directive to Take Action); and be it further

RESOLVED, That our AMA study the issues around price transparency, including the feasibility of providing accurate and easily understandable costs of tests, procedures, medications, and other costs related to medical care. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY

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;

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;

Value-Based Decision-Making in the Health Care System D-155.994
1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.
Citation: (CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 230, I-14; Reaffirmation I-15)

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.
Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19;

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy

and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19;

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.
Citation: Sub. Res. 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;

Strategies to Address Rising Health Care Costs H-155.960
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols;

relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
Citation: CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmation: A-22;

Value-Based Decision-Making in the Health Care System H-450.938
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.
Citation: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmation: I-17; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed: CMS Rep. 2, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-23)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer

Referred to: Reference Committee A

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1 Whereas, In 2019, 1,752,735 new cancer cases were reported in the United States[1]; and
2
3 Whereas, Cancer treatments may lead to alopecia[2]; and
4
5 Whereas, Alopecia affects approximately 65% of patients undergoing chemotherapy, 75- 100%
6 of patients undergoing head and neck radiation, and a variable number of patients undergoing
7 targeted therapies, immunotherapies, stem cell transplants, and endocrine therapies[3]; and
8
9 Whereas, Hair loss as a result of cancer treatment may have a variety of manifestations such as
10 patchy hair loss in areas of high friction, diffuse hair loss on the scalp, hair loss accompanied by
11 dermatitis and cutaneous ulceration, and scarring alopecia[2]; and
12
13 Whereas, In a cross-sectional survey of breast cancer patients, 55.3% of patients reported
14 higher stress levels due to alopecia which resulted in decreased body image, emotional and
15 social functioning, and depression[4]; and
16
17 Whereas, Many female cancer patients associated the experience of hair loss with a loss of
18 femininity and sense of self identity[5]; and
19
20 Whereas, For many female cancer patients, hair loss served as a visible sign of their cancer
21 diagnosis and affected their social and personal relationships, with many women expressing
22 concern about the impact alopecia had on their children[5]; and
23
24 Whereas, Many patients report feeling poorly prepared for the psychologically distressing nature
25 of hair loss and change of appearance[6]; and
26
27 Whereas, A prior study found that participants who were shown photos of individuals with
28 alopecia were less comfortable with having physical contact with or hiring individuals with
29 alopecia compared to those without hair loss[7]; and
30
31 Whereas, Many patients with cancer wear wigs to cope with the psychological and societal
32 effects of hair loss[8]; and
33
34 Whereas, Wigs are either made from synthetic fiber, human hair, or a mixture of synthetic fiber
35 and human hair; and
36
37 Whereas, The best-quality, most natural-appearing wigs are often composed of human hair and
38 cost $800-$3000[9]; and

1 Whereas, Payers such as Medicare do not deem wigs to be medically necessary[10]; and
2
3 Whereas, Medicare (Part A and Part B) and many private insurers do not cover the cost for wigs
4 for patients who experience alopecia as a result of cancer treatment[11]; and
5
6 Whereas, While charities may assist with wig donations, many patients pay out of pocket for
7 their wigs; and
8
9 Whereas, Wigs help alleviate the psychological effects of hair loss and improve the integration
10 of patients into social contexts during their illness journey[12]; therefore be it
11
12 RESOLVED, That our American Medical Association urge all payers to consider that wigs, cold
13 caps, and medically necessary cranial prosthetics may have significant benefits to improve the
14 quality of life for patients with cancer (New HOD Policy); and be it further
15
16 RESOLVED, That our AMA work with relevant stakeholders such as the Centers for Medicare
17 and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps, and
18 medically necessary cranial prosthetics for patients with alopecia secondary to cancer
19 treatments (Directive to Take Action); and be it further
20
21 RESOLVED, That our AMA work with all relevant medical specialty societies, third party payers,
22 including The Centers for Medicare & Medicaid Services (CMS), and other national
23 stakeholders as deemed appropriate to require third party payers to include reimbursement for
24 wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia
25 secondary to cancer treatment. (Directive to Take Action)

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

Received: 5/5/23

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992
(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.
Citation: (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13)

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-23)

Introduced by: New York

Subject: Medicare Coverage of OTC Nicotine Replacement Therapy

Referred to: Reference Committee A

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1 Whereas, Nicotine dependence causes patients to continue smoking despite well-known harms;
2 and
3
4 Whereas, Nicotine replacement therapy (NRT), especially dual therapy which is now the
5 evidence-based standard of care is effective at helping smokers to stop smoking essentially
6 doubling or tripling successful quit rates; and
7
8 Whereas, Medicare Part D prescription medication plans, by law, do not cover over the counter
9 (OTC) products, Medicare Parts A and B do not cover OTC products, and Medicare Part C
10 (Medicare disadvantage plans) do not cover OTC products or do so in very limited ways; and
11
12 Whereas, Many persons who only have Medicare insurance coverage have very limited
13 incomes, and may have limited fixed budgets, yet may have chronic mental illness, both social
14 determinants of health associated with double or triple the national average rate of smoking,
15 and people with psychiatric illnesses have much more difficulties trying to quit smoking; and
16
17 Whereas, OTC NRT can be prohibitively expensive to members of lower sociodemographic
18 groups thereby presenting a barrier to facilitating treatment of nicotine dependence; and
19
20 Whereas, The expense and harm from tobacco related illnesses is so vast: chronic smoking
21 damages nearly every organ of the body, remains the leading cause of preventable disease,
22 disability, and death in the United States and costs the United States hundreds of billions of
23 dollars each year therefore it is worth carving out; therefore be it
24
25 RESOLVED, That our American Medical Association advocate for over the counter (OTC)
26 nicotine replacement therapies, excluding vaping products, to be carved out from the non-
27 coverage by Medicare of OTC products and be specifically covered when prescribed by
28 physicians who care for patients with Medicare, Medicare Part D, or Medicare Part C coverage.
29 (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.
Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-23)

Introduced by: American Thoracic Society

Subject: Regulation of “Cool/Non-Menthol” Tobacco Products

Referred to: Reference Committee B

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1 Whereas, Smoking leads to disease and disability and harms nearly every organ of the body;
2 and
3
4 Whereas, Cigarette smoking remains the leading cause of preventable disease, disability, and
5 death in the United States; and
6
7 Whereas, The tobacco industry spends billions of dollars each year on marketing cigarettes;
8 and
9
10 Whereas, In 2020, 12.5% of U.S. adults (an estimated 30.8 million people) currently smoked
11 cigarettes: 14.1% of men, 11% of women; and
12
13 Whereas, Each day, about 1,600 youth try their first cigarette; and
14
15 Whereas, The Food and Drug Administration has proposed rules to ban menthol flavored
16 cigarettes and flavored cigars; and
17
18 Whereas, The state of California has enacted legislation banning menthol cigarettes; and
19
20 Whereas, Several tobacco companies have introduced new tobacco products that produce the
21 same “cooling” sensation of a menthol product, but does not include a menthol taste; and
22
23 Whereas, The flavoring additives used to achieve the cooling sensation work on the same
24 receptors as does the menthol flavors; and
25
26 Whereas, The tobacco industry has marketed these new “cooling/non-menthol” products using
27 terms like “cool” and “fresh” – the same terms used to describe menthol tobacco products; and
28
29 Whereas, Documents released as a result of the tobacco action master settlement showed the
30 tobacco industry knowingly and intentionally used flavored tobacco products to lure children and
31 marginalized communities into tobacco addiction; and
32
33 Whereas, The tobacco industry appears to be designing new products to intentionally evade
34 menthol bans and to continue marketing flavored tobacco products to youth and marginalized
35 populations; therefore be it
36
37 RESOLVED, That our American Medical Association advocate that tobacco products that use
38 additives that create a “cooling effect” should be treated as a tobacco product with a
39 characterizing flavor for legal and regulatory purposes. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/8/23

RELEVANT AMA POLICY

Opposition to Exempting the Addition of Menthol to Cigarettes H-495.976
Our AMA: (1) will continue to support a ban on the use and marketing of menthol in cigarettes as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes.
Citation: BOT Action in response to referred for decision Res. 436, A-08; Modified: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-23)

Introduced by: Michigan

Subject: Vision Qualifications for Driver's License

Referred to: Reference Committee B

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1 Whereas, Current vision qualifications for operating motor vehicles were derived by various
2 states in the 1920s and 1930s; and
3
4 Whereas, The American Medical Association (2003) in its Physician's Guide to Assessing and
5 Counseling Older Drivers stated, "Although many states currently require far visual acuity of
6 20/40 for an unrestricted license, current research indicates that there is no scientific basis for
7 this cut-off. In fact, studies undertaken in some states have demonstrated that there is no
8 increased crash risk between 20/40 and 20/70 resulting in several new state requirements;" and
9
10 Whereas, Good data exists to recommend reconsideration of visual acuity standards in many
11 states; and
12
13 Whereas, It has been well known that some persons with reduced acuity continue to drive
14 safely; and
15
16 Whereas, Persons with significant visual field defects that violate state licensure requirements
17 can be taught to drive safely; and
18
19 Whereas, Tests for cognitive well-being are generally not used in motor vehicle licensure testing
20 protocols in most states; and
21
22 Whereas, Denying drivers licensure without evidence to support that denial frequently causes
23 isolation, depression, and increased expenses for ill-advised and unnecessary medical visits;
24 and
25
26 Whereas, Crash avoidance systems, unimagined one century ago, are routinely incorporated in
27 automotive and roadway systems; and
28
29 Whereas, Autonomous vehicle technology is in advanced stages of development and has been
30 supported by the Michigan State Medical Society (MSMS), the AMA, and the National Highway
31 Traffic and Safety Administration (NHTSA); and
32
33 Whereas, It is well known that a large proportion of mortality involved auto crashes are
34 accompanied by "driver error;" and
35
36 Whereas, Studies have been performed that show that drivers with the visual acuity less than
37 20/50 can be safe and competent drivers; and
38
39 Whereas, The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a
40 Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology

1 (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing,
2 perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously
3 advocating for simple appropriate tests where cognitive decline is suspected; therefore be it
4
5 RESOLVED, That our American Medical Association engage with stakeholders including, but
6 not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety
7 Commission, and interested state medical societies, to make recommendations on standardized
8 vision requirements for unrestricted and restricted driver's licensing privileges. (Directive to Take
9 Action)

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

Received: 5/3/23

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3. Rubin, G., Ng, E., et al., (2007) A prospective, population-based study of the role of visual impairment in motor vehicle crashes among older drivers: the SEE Study. (Investigative Ophthalmology & Visual Sciences) 48, (4) :1483-1491. a. Essential Quote: "Conclusions: Glare sensitivity, visual field loss and UFOV (useful field of vision) were significant predictors of crash involvement. Acuity, contrast sensitivity and stereo acuity were not associated with crashes. These results suggest that current vision screening for driver's licensure, based primarily on visual acuity, may miss important aspects of visual impairment." Owsley, C., Mc Gwin, G., (2010) Vision and driving. (Vision Research) 50:2348-2361. a. Essential Quote: "Based upon the research to date it is clear that if there is an association between visual acuity and driver safety, it is at best weak,...how does one rectify this conclusion in light of the significant findings from performance-based studies? One important consideration in this regard is that visual acuity related driving skill (e.g., sign recognition many not be crucial to the safe operation of a vehicle. Reading signage may be important for route planning or maintaining regulatory compliance with the "rule of the road" but it may not be critical for collision avoidance. " Owsley, C., Wood,. J., et al., (2015). A road map for interpreting the literature on vision and driving. (Survey of Ophthalmology) 60:250-262. Tervo, T., (2018) Driver's health and fitness as a cause of a fatal motor vehicle accident in Finland. (The Eye, The Brain, and The Auto) 2018 (Link and /or abstract available from CAR author PCH). Keeney, A., (1976) The visually impaired driver and physician responsibilities. (American Journal of Ophthalmology) 82 (5):799-801. Fonda, G., (1989) Legal blindness can be compatible with safe driving. (Ophthalmology) 96 (10):1457-1459. Appel, S., Brilliant, R., et al., (1990) Driving with visual impairment: Facts and Issues. (Journal of Visual Rehabilitation) 4: 19-31. Peli, E., (2008) Driving with low vision: who, where, when and why. In Robert Massof, editor. (Albert and Jokobiec's Principles and Practice of Ophthalmology) 3rd Ed. Philadelphia, PA. Elsevier, 5369-5376. PLoS ONE
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RELEVANT AMA POLICY

E8.2 Impaired Drivers & Their Physicians
A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should: (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene. (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments. (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses. (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely. (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver: (i) when the physician identifies a medical condition clearly related to the ability to drive; (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or (iii) when required by law.(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician. (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-23)

Introduced by: Michigan

Subject: Reimbursement for Postpartum Depression Prevention

Referred to: Reference Committee B

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1 Whereas, The Centers for Disease Control and Prevention (CDC) reports that more than one in
2 eight women with a recent live birth experience postpartum depression; and
3
4 Whereas, Untreated mood and anxiety disorders amongst pregnant women and new mothers
5 cost approximately $14.2 billion over five years, with more than half the costs occurring within
6 the first year due to pregnancy and birth complications; and
7
8 Whereas, The United States Preventive Services Task Force (USPSTF) recommends
9 prevention of depression in pregnant and postpartum women by a wide range of providers in
10 standard prenatal care settings and provides a grade of B; and
11
12 Whereas, Section 2713 of the Affordable Care Act requires private insurers to cover preventive
13 services recommended by the USPSTF with a grade of A or B, along with those recommended
14 by the Advisory Committee on Immunization Practices (ACIP), Bright Futures, and the Health
15 Resources and Services Administration's (HRSA's) guidelines for women's health; and
16
17 Whereas, The Affordable Care Act requires insurers to cover these services with no cost-
18 sharing (i.e., no deductible and no co-pay); and
19
20 Whereas, Given this USPSTF recommendation to provide postpartum depression prevention,
21 these services should be reimbursable under the Affordable Care Act; and
22
23 Whereas, The USPSTF recommends two postpartum depression prevention programs,
24 including the Reach Out, Stay Strong, Essentials for Mothers of Newborns (ROSE) Program
25 and the Mothers & Babies (MB) Program; and
26
27 Whereas, Research has shown that receiving either the MB or ROSE intervention during
28 pregnancy reduces the odds of developing postpartum depression by 53 percent and 50
29 percent respectively; and
30
31 Whereas, Prenatal health care providers currently must provide a mental health diagnosis code
32 to bill for postpartum depression prevention, and thus primary prevention does not qualify; and
33
34 Whereas, Useful Current Procedural Terminology Codes (CPT) for postpartum depression
35 prevention include but are not limited to 98960-98962 regarding a "non-physician health care
36 professional uses a standard curriculum to educate a patient about his or her disease or
37 disorder to enable the patients and caregivers to effectively manage disease;" and
38
39 Whereas, California reimburses for these services, but is currently the only state that has done
40 so; and

Whereas, Administration of postpartum prevention interventions by nurses, health educators, community health workers, and other paraprofessionals has been shown to be non-inferior to licensed mental health providers in reducing rates of postpartum depression; therefore be it

RESOLVED, That our American Medical Association amend Policy H-420.95, "*Improving Mental Health Services for Pregnant and Postpartum Mothers*," by addition and deletion to read as follows:

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) will advocate for evidence-based postpartum depression prevention services to be recognized as the standard of care for all federally-funded health care programs for pregnant women. (Modify Current HOD Policy)

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

Received: 5/3/23

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RELEVANT AMA POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Citation: Res. 102, A-12; Modified: Res. 503, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-23)

Introduced by: Michigan

Subject: Reducing Stigma for Treatment of Substance Use Disorder

Referred to: Reference Committee B

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1 Whereas, Treatment and services for substance use disorders are health care and should not
2 be considered a “carve out” or an exception to health care; and
3
4 Whereas, Medicaid benefits may provide coverage for transportation costs for patients traveling
5 to/from an office visit for general health care or mental health care visits; and
6
7 Whereas, Treatment of substance use disorder (SUD) may also require transportation to office
8 visits for treatment with medication for opioid use disorder (MOUD) and/or for counseling; and
9
10 Whereas, The cost of transportation may be a barrier to ongoing participation in the treatment
11 and recovery process for patients with SUD; and
12
13 Whereas, The cost of transportation (and lack of access) may be an added barrier to accessing
14 MOUD for the uninsured, underinsured, or patients insured through Medicaid; and
15
16 Whereas, This lack of coverage for transportation costs for patients seeking treatment for SUD
17 potentially adds to the stigma for SUD and may discourage people from accessing treatment;
18 therefore be it
19
20 RESOLVED, That our American Medical Association support and advocate for coverage for
21 transportation costs for all Medicaid or Medicare health care services without a “carve out” for
22 patients diagnosed with a substance use disorder who are being treated with medication for
23 opioid use disorder. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-23)

Introduced by: Michigan

Subject: Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

Referred to: Reference Committee B

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1 Whereas, Title 18 U.S. Code Section 3553 “Imposition of a Sentence” defines “violent offense”
2 as “a crime of violence, as defined in [Title18, Part I, Chapter 1,] Section 16 [Crime of Violence
3 Defined], that is punishable by imprisonment;” and
4
5 Whereas, A “crime of violence” under the U.S. Code of Public Law of the 98th Congress under
6 Title 18, Part I, Chapter 1, Section 16, Subsection (a) is defined as “an offense that has as an
7 element the use, attempted use, or threatened use of physical force against the person or
8 property of another;” and
9
10 Whereas, The Gun Control Act of 1988 only prohibits the sale to, and possession of firearms by,
11 a person indicted or convicted of misdemeanors punishable by more than two years of
12 imprisonment; and
13
14 Whereas, “Handgun possession is prohibited for people who have committed a violent
15 misdemeanor punishable by less than 1 year of imprisonment” in five states including California,
16 Hawaii, New York, Connecticut, and Maryland since 2016; and
17
18 Whereas, Aggravated assaults accounted for 68.2 percent of violent crimes reported to law
19 enforcement in 2019; and
20
21 Whereas, California saw a “37% lower gun death rate than the national average” as of June
22 2022 since enacting firearm safety laws; and
23
24 Whereas, Hawaii had the lowest gun death rate at 2.5 deaths per capita in 2019 following its
25 history of strict firearm legislation; and
26
27 Whereas, 15 states have adopted a similar policy which bans the purchase of firearms for those
28 that have been convicted of a violent misdemeanor; and
29
30 Whereas, States like California and Hawaii have subsequently rescinded firearm possession for
31 periods of 10 years up to indefinite suspension of possession, respectively; and
32
33 Whereas, Adoption of this and similar policies by other states have correlated in an 18 percent
34 reduction in total homicide rates; and
35
36 Whereas, The American Medical Association has set precedent for supporting firearm
37 restrictions in purchasing and possession in the cases of domestic violence; therefore be it

1 RESOLVED, That our American Medical Association study the effect of including a rescindment
2 period of 10 years for the possession of a firearm by persons convicted of a violent offense in
3 accordance with other established rescindment periods adopted by other states. (Directive to
4 Take Action)

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

Received: 5/3/23

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5 Siegel M, Pahn M, Xuan Z, Fleegler E, Hemenway D. The Impact of State Firearm Laws on Homicide and Suicide Deaths in the USA, 1991-2016: a Panel Study. J Gen Intern Med. 2019 Oct;34(10):2021-2028. doi: 10.1007/s11606-019-04922-x. Epub 2019 Mar 28. PMID: 30924089; PMCID: PMC6816623.
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RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-23)

Introduced by: Michigan

Subject: Address Disproportionate Sentencing for Drug Offenses

Referred to: Reference Committee B

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1 Whereas, Crack cocaine is no more dangerous than powdered cocaine, it presents different
2 dangers because it is smoked or injected while powder cocaine is snorted; and
3
4 Whereas, Current sentencing disparities would land a powder-cocaine offender in prison for one
5 day and put a crack-cocaine offender behind bars for 18 days (1:18) for possession of the same
6 amount; and
7
8 Whereas, Five grams of crack cocaine is punished like 90 grams of powder cocaine; and
9
10 Whereas, The crack and powder cocaine sentencing disparity has disproportionately impacted
11 people of color for the past three decades, a vestige of the War on Drugs; and
12
13 Whereas, 85 percent of offenders convicted under the crack cocaine sentencing law (Anti-Drug
14 Abuse Act of 1986) are Black Americans; and
15
16 Whereas, The War on Drugs continues to disproportionately consume human potential and
17 inflict trauma and suffering on communities of color despite wide-ranging evidence of its
18 misguided origins and devastating impacts; and
19
20 Whereas, Incarceration is linked to adverse health effects extending far beyond prison walls;
21 and
22
23 Whereas, People who have been incarcerated face higher rates of mental illness, substance
24 use disorder, communicable diseases, and chronic diseases; and
25
26 Whereas, Individuals incarcerated have lower life expectancies, with each year in prison taking
27 two years of life; and
28
29 Whereas, The majority of an estimated five hundred thousand people incarcerated for drug
30 offenses are arrested for simple possession, a nonviolent crime; and
31
32 Whereas, 74 percent of the public (majorities across the political spectrum) support ending the
33 sentencing disparity between crack and powder cocaine offenses; therefore be it
34
35 RESOLVED, That our American Medical Association actively lobby for federal and state
36 legislation aimed at eliminating the national crack and powder cocaine sentencing disparity
37 (from 18:1 to 1:1) and apply it retroactively to those already convicted or sentenced (Directive to
38 Take Action); and be it further

1 RESOLVED, That our AMA collaborate with appropriate stakeholders, including, but not limited
2 to, courts, government agencies, professional organizations, and criminal/social justice
3 organizations to advocate for addressing excessive legal punishments for low-level, nonviolent
4 drug crimes at state and federal levels. (Directive to Take Action)

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

Received: 5/3/23

REFERENCES

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2. Prison Policy Initiative https://www.prisonpolicy.org/reports.html
3. Booker and Durbin Announce Legislation to Eliminate Federal Crack and Powder Cocaine Sentencing Disparity https://www.booker.senate.gov/news/press/booker-and-durbin-announce-legislation-to-eliminate-federal-crack-and-powder-cocaine-sentencing-disparity
4. A bill that would have impacted racial disparity in cocaine crimes died in the Senate https://www.michiganradio.org/2023-01-09/a-bill-that-would-have-impacted-racial-disparity-in-cocaine-crimes-died-in-the-senate
5. The Racist Roots of the War on Drugs and the Myth of Equal Protection for People of Color https://lawrepository.ualr.edu/cgi/viewcontent.cgi?article=2106&context=lawreview

RELEVANT AMA POLICY

Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession H-95.910

1. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.
2. Our AMA supports automatic expungement, sealing, and similar efforts regarding an arrest or conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching the age of majority.
3. Our AMA will inquire to the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Federation of State Medical Boards, and other relevant medical education and licensing authorities, as to the effects of disclosure of a cannabis related offense on a medical school, residency, or licensing application.
4. Our AMA supports ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.

Citation: BOT Rep. 17, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-23)

Introduced by: Michigan

Subject: Equitable Interpreter Services and Fair Reimbursement

Referred to: Reference Committee B

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1 Whereas, All patients deserve equitable, fair, and high-level care in a language in which they
2 can comprehend; and
3
4 Whereas, More than 25 million Americans speak English "less than very well," according to the
5 U.S. Census Bureau, and the National Center for Health Statistics reports about 37.6 million
6 adults have difficulty with their hearing; and
7
8 Whereas, This population is less able to access health care and is at higher risk of adverse
9 outcomes such as medication complications, noncompliance, and decreased patient
10 satisfaction; and
11
12 Whereas, Title VI of the Civil Rights Act and Executive Order 13166 mandate that interpreter
13 services be provided for patients with limited English proficiency (LEP) who need this service,
14 and Section 1557 of the Affordable Care Act has also created protections for medical interpreter
15 services as part of its protections from discrimination on the basis of race, color, or country of
16 origin; and
17
18 Whereas, Unfortunately, there are currently only 14 states and 1 district that offer
19 reimbursements for this service, including Connecticut, District of Columbia, Iowa, Idaho,
20 Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (only sign language
21 interpreters), Utah, Vermont, Washington, and Wyoming; and
22
23 Whereas, In the aforementioned states, providers can claim an administrative match for 50-75
24 percent of translation and interpretation claimed as an administrative expense if they are not
25 already reimbursed as part of the direct service rates; and
26
27 Whereas, As of 2009, oral interpreter services can be claimed using billing code T-1013 along
28 with the Current Procedural Terminology (CPT) Code appropriate for the clinical encounter; and
29
30 Whereas, In the 36 other states in which reimbursement for interpreter services is not codified,
31 physicians sometimes have to bear the burden of the cost, which can cost up to $150.00/hour;
32 and
33
34 Whereas, Studies have shown enforcement of hospital regulations to provide interpreters is
35 inconsistent, and lack of reimbursement decreases hospital incentive to comply and many
36 hospitals are not providing language services in a manner consistent with related CLAS
37 standards; and
38
39 Whereas, Although coding methods are available, their use is limited because payers expect
40 physicians to absorb the cost of interpretation services as part of their business expenses; and

1 Whereas, In 2000, the CPT Editorial Panel responded to a request of the House of Delegates to
2 review the development of a CPT Code for use of medical interpreters by using the modifier
3 "32;" and
4
5 Whereas, In addition to accrued cost, physicians often spend more time per visit with patients
6 requiring medical interpreters due to initial set-up, dialogue in multiple languages, as well as
7 additional clarifications; therefore be it
8
9 RESOLVED, That our American Medical Association support the standardization of physician
10 reimbursement in regard to interpreter services, whether it be through the usage of a Current
11 Procedural Terminology (CPT) code or direct reimbursement by payers including Medicaid
12 programs and Medicaid managed care plans (New HOD Policy); and be it further
13
14 RESOLVED, That our AMA reaffirm Policy D-385.957, "*Certified Translation and Interpreter*
15 *Services,"* which advocates for legislative and/or regulatory changes to require that payers
16 including Medicaid programs and Medicaid managed care plans cover interpreter services and
17 directly pay interpreters for such services and relieve the burden of the costs associated with
18 translation services. (Reaffirm HOD Policy)

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

Received: 5/5/23

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RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Citation: Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21;

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
Citation: CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21;

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;
(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;
(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;
(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and
(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17;

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.
Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:232
(A-23)

Introduced by: Minnesota

Subject: Supervised Injection Facilities (SIFs) Allowed by Federal Law

Referred to: Reference Committee B

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1 Whereas, Drug overdose deaths have risen fivefold in the past 20 years in the United States[1];
2 and
3
4 Whereas, Between 2020 and 2021, in the wake of the COVID-19 pandemic, the age-adjusted
5 rate of drug overdose deaths rose more than 14% in the United States, with 106,699 drug
6 overdose deaths occurring in 2021[2]; and,
7
8 Whereas, A rigid, treatment-only approach to substance use disorder (SUD) is not sufficient to
9 reduce drug overdoses among people with SUD who (a) are not accepting of treatment, or (b)
10 have accepted treatment but have since relapsed on a difficult road to recovery; and
11
12 Whereas, People with SUD who die from drug overdose will never have the opportunity to
13 successfully enter or complete treatment; and
14
15 Whereas, In other countries, the introduction of supervised injection facilities (SIFs), or facilities
16 that allow people who use drugs to use previously obtained substances under the supervision of
17 healthcare professionals, has been associated with lower rates of overdose-induced mortality
18 and morbidity, safer injection behavior, greater take-up of addiction treatment programs, and
19 constant, or lower, rates of crime and drug-related public nuisance[3,4]; and
20
21 Whereas, While the evidence supporting SIFs in other countries may not be generalizable to the
22 United States, it supports the reasonableness of conducting American-based SIF pilot programs
23 and evaluations; and
24
25 Whereas, Any operation of an SIF, including SIF pilot programs and evaluations, are prohibited
26 under federal law[5]; and
27
28 Whereas, In 2021, a federal appellate court ruled in favor of a lawsuit originally filed by the
29 Trump Administration against a Philadelphia-based SIF in 2019[6]; and
30
31 Whereas, The Biden Administration has not actively filed suit against, or actively permitted, the
32 operation of two SIFs in New York City that have been operating since November 2021[7]; and
33
34 Whereas, Between November 2021 and December 2022, the two operating SIFs in New York
35 City served more than 2,300 people with substance use disorder and reversed more than 700
36 overdoses[8]; and
37
38 Whereas, The uncertainty about Executive Branch enforcement of the federal law prohibiting
39 SIFs deters the potential operators of American-based SIF pilot programs and evaluations; and

Whereas, While the current policy of this American Medical Association supports American-based SIF pilot programs and evaluations, it does not sufficiently address the need for this American Medical Association to pursue the amendments to federal law, and/or commitments from the Executive Branch, necessary to address the legal concerns of potential operators of American-based SIF pilot programs and evaluations[9]; therefore be it

RESOLVED, That our American Medical Association amend policy H-95.925, "*Pilot Implementation of Supervised Injection Facilities,"* by addition to read as follows:

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, including supporting changes to federal law to permit the operation of pilot SIFs in the United States. Until federal law permits the operation of pilot SIFs in the United States, our AMA will regularly pursue explicit commitments from each active presidential administration that federal lawsuits will not be filed against operators of pilot SIFs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

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2. Ibid.
3. AMA wants new approaches to combat synthetic and injectable drugs. American Medical Association. https://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs. Published June 12, 2017. Accessed February 21, 2023.
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9. Pilot Implementation of Supervised Injection Facilities H-95.925. AMA Policy Finder. American Medical Association. https://policysearch.ama-assn.org/policyfinder/detail/Supervised%20injection?uri=%2FAMADoc%2FHOD.xml-H-95.925.xml. Published 2017. Accessed February 21, 2023.

RELEVANT AMA POLICY

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: 233
(A-23)

Introduced by: Missouri

Subject: Dobbs – EMTALA Medical Emergency

Referred to: Reference Committee B

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1 Whereas, The U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health*
2 *Organization* found that no constitutional right to abortion of a pregnancy was found to exist
3 under Constitution of the United States; and
4
5 Whereas, The matter of what types of abortions of pregnancies would be considered legal
6 versus what types of abortions of pregnancies would be considered illegal was therefore left to
7 the states, each of which could define these matters independently; and
8
9 Whereas, The diagnosis of the existence of certain abnormal conditions of pregnancy
10 represents *upon their recognition* a threat to the life and/or reproductive potential of a woman,
11 because delays in remediating these conditions increases the risks to the mother of morbidity
12 and mortality; and
13
14 Whereas, The federal law that provides the greatest clarity on this matter, and which governs
15 the obligations of physicians and medical teams as well as those who manage or operate the
16 facilities at which care of pregnant women is rendered, is the Emergency Medical Treatment
17 and Active Labor Act, or "EMTALA"; and
18
19 Whereas, EMTALA codifies that an "emergency medical condition" is defined to exist *upon the*
20 *recognition of the threat* of loss of life or loss of function of any bodily system; and
21
22 Whereas, It is incontrovertible that conditions including those such as ectopic pregnancies,
23 premature rupture of membranes, and other conditions represent a clear danger to the life and
24 health of the mother, *upon the recognition of these conditions*, even before the development of
25 "unstable" vital signs such as tachycardia or hypotension; and
26
27 Whereas, EMTALA not only clearly defines the obligations of the medical care team, but also
28 supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States
29 Constitution; therefore be it
30
31 RESOLVED, That our American Medical Association advocate for policies to ensure that all
32 patients receive prompt, complete and unbiased emergency health care that is medically sound
33 and evidence-based, in compliance with the federal Emergency Medical Treatment and Active
34 Labor Act (EMTALA). (Directive to Take Action)

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

Received: 5/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Medicare Physician Fee Schedule Updates and Grassroots Campaign

Referred to: Reference Committee B

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1 Whereas, Since 1992, Medicare payment to physicians has been based on the Medicare
2 Physician Fee Schedule (PFS), whether those services are provided in physician offices,
3 hospitals, ambulatory surgical centers, skilled nursing facilities, hospices, outpatient dialysis
4 facilities, clinical laboratories, or beneficiaries' homes. Payment to physicians for services
5 provided in a physician's office is based on a single rate, while payment for services provided in
6 other facilities is proportioned according to the resources available to the physician; and
7
8 Whereas, The required statutory update to the conversion factor of 0% for calendar year (CY)
9 2023, the expiration of the 3% supplemental increase to Medicare PFS for 2022, and a budget
10 neutrality adjustment of 1.47%, the final Medicare PFS CF for CY 2023 decreased by 2% from
11 CY 2022 to CY 2023 from $34.60 to $33.88. Despite this cut, Medicare stated "The CY 2023
12 Medicare PFS final rule is one of several rules that reflect a broader Administration-wide
13 strategy to create a more equitable health care system that results in better accessibility, quality,
14 affordability, and innovation;" and
15
16 Whereas, Payments and administrative burdens on physician practices are eroding physicians'
17 ability to focus on patients, driving burnout among physicians generally, and threatening
18 physicians ability to practice; and
19
20 Whereas, Our American Medical Association and myriad other medical organizations support
21 HR 2474, "Strengthening Medicare for Patients and Providers Act"; therefore be it
22
23 RESOLVED, That our American Medical Association's top priority be to advocate for positive
24 annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual
25 inflation, cost of living, and practice expense increases (Directive to Take Action); and be it
26 further
27
28 RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national
29 grassroots campaign that educates patients about how lack of sufficient positive updates to the
30 physician fee schedule places physician practice survivability and access to quality health care
31 at risk (Directive to Take Action); and be it further

32 RESOLVED, That this newly-created AMA grassroots campaign actively engage America's
33 patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare
34 PFS updates to help ensure the survivability of physician practices and access to quality health
35 care for all. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-23)

Introduced by: American College of Emergency Physicians

Subject: EMS as an Essential Service

Referred to: Reference Committee B

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1 Whereas, Longer delays for ambulances for emergency and non-emergency calls for service is
2 associated with an increase in mortality[1]; and
3
4 Whereas, Delays for ambulances have been increasing in the past few years, in part due to
5 increasing loss of workforce which started prior to the COVID-19 pandemic and has been
6 exacerbated by the pandemic[2]; and
7
8 Whereas, 70% of Emergency Medical Services (EMS) clinicians plan to leave the field in the
9 next 4 years[3]; and
10
11 Whereas, 26% of those leaving cited compensation as the reason for their leaving and 45% felt
12 that this was the main problem impacting retention[3]; and
13
14 Whereas, EMS clinician turnover is as high has 40% in 2022[4], compared to almost half that rate
15 within the publicly funded fire department based EMS model[5]; and
16
17 Whereas, Every state defines fire departments and fire protections as an essential function of
18 government and provides a funding mechanism for the same[6]; and
19
20 Whereas, Only 11 states define EMS as an essential service, limiting funding and access to
21 federal funds for the services that are provided[6], indicating that declaring EMS as essential
22 service alongside fire protection could help improve funding, salaries, and provider retention;
23 therefore be it
24
25 RESOLVED, That our American Medical Association recognize that the provision of Emergency
26 Medical Services is an essential service of government and is best overseen by physicians with
27 specialized training in medical direction for Emergency Medical Services (New HOD Policy);
28 and be it further
29
30 RESOLVED, That our AMA work with the American College of Emergency Physicians (ACEP),
31 the National Registry of Emergency Medical Technicians (NREMT), the National Association of
32 EMS Physicians (NAEMSP), the National Association of State EMS Officials (NASEMSO), and
33 other relevant stakeholders to create model legislation at the state level to establish funding for
34 Emergency Medical Services as an essential service (Directive to Take Action); and be it further
35
36 RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an
37 essential service. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES
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2. Wright W. "Issue of ambulance response times sheds light on larger EMS industry problems." *Spectrum News 1*. Online https://spectrumlocalnews.com/nys/rochester/news/2021/07/02/issue-of-ambulance-response-times-sheds-light-on-larger-ems-industry-problems 2 Jul 2021.
3. Minge AW, Hatt K. "What Paramedics Want in 2022." *Fitch & Associates.* 1 Aug 2022.
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5. Sargent C, Dreiman B, Jose P. "Recruit, Train, and Retain." *Fire Engineering*. Online. https://www.fireengineering.com/webcasts/recruit-train-and-retain/#gref. 19 Jul 2022.
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RELEVANT AMA POLICY

On-Site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.
Citation: BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Overcrowding and Hospital EMS Diversion H-130.945
It is the policy of the AMA:
(1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds;
(2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department;
(3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups;
(4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;
(5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and
(6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.
Citation: CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

Addressing Payment and Delivery in Rural Hospitals D-465.998

1. Our AMA will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

Citation: CMS Rep. 9, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-23)

Introduced by: American College of Cardiology

Subject: AMA Support for Nutrition Research

Referred to: Reference Committee B

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1 Whereas, The Office of Nutrition Research (ONR) focuses on advancing nutrition science to
2 promote health, and to reduce the burden of diet-related diseases and nutrition health
3 disparities. In January 2021, ONR was relocated to the National Institutes of Health (NIH) Office
4 of the Director (OD) to better coordinate and lead research functions across NIH institutes and
5 centers; and
6
7 Whereas, Nutrition research has been chronically underfunded. A 2019 NIH analysis compared
8 the amount of dedicated NIH funding for risk factors of death and disability and concluded that
9 large disparities exist between the top causes of poor health and the research funding allocated
10 to address them—with the largest gap existing for nutrition. Despite this pressing need for more
11 investment, funding levels for nutrition research and training have remained flat since FY2015;
12 and
13
14 Whereas, The President's budget includes $121 million to support nutrition research, including
15 investments that will advance the goals of the White House National Strategy on Hunger,
16 Nutrition, and Health. Resources will expand the efforts of the NIH Common Fund Community
17 Partnerships to Advance Science for Society, and help to ensure diversity and inclusion in
18 nutrition, health, and food security research. Funding will also allow NIH to focus on expanding
19 and diversifying the nutrition science workforce and investing in creative new approaches to
20 advance research regarding the prevention and treatment of diet-related diseases, including the
21 Food is Medicine initiative; and
22
23 Whereas, Poor nutrition is a major driver of diet-related diseases, including heart disease, type
24 2 diabetes, obesity, hypertension, and some cancers, and has staggering costs to society. Diet-
25 related diseases are the number one cause of death and disability in the United States. The
26 combined health care spending and lost productivity from suboptimal diets costs the economy
27 $1.1 trillion each year. A strong investment in NIH ONR would expand and accelerate scientific
28 discoveries that positively impact public health, health care costs, equity, the economy, national
29 security, and the nation's resilience to new threats; and
30
31 Whereas, The nutrition security crisis in this country is deeply inequitable, with people of color
32 facing higher rates of diabetes, obesity, stroke, and heart disease than white people. Properly
33 investing in nutrition research in this country is essential to understanding and combatting the
34 drivers of this inequitable harm and to building a more diverse nutrition science workforce. Both
35 of these steps are essential to improving health equity in this country; and
36
37 Whereas, Diet-related illness also undermines our country's military readiness. A striking 77% of
38 young adults are ineligible for military service, with obesity as the largest disqualifier; therefore
39 be it

1 RESOLVED, That our American Medical Association seek national legislation in support of the
2 President's FY24 Budgetary request that the National Institutes of Health's (NIH's) Office of
3 Nutrition Research (ONR) receive at least $121,000,000, as this level of funding would enable
4 ONR to secure the leadership, organizational structure, and resources to effectively fulfill its
5 important mission. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-23)

Introduced by: California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, The Society of Thoracic Surgeons

Subject: Prohibiting Covenants Not-To-Compete in Physician Contracts

Referred to: Reference Committee B

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1 Whereas, Non-compete agreements are contracts whereby an employee agrees not to enter
2 direct competition with their employer once the employment term is over, regardless of which
3 party terminates the contract; and
4
5 Whereas, While intention of such agreements is to reduce competition, it has also been shown
6 to negatively impact wages and employment mobility; and
7
8 Whereas, The Federal Trade Commission (FTC) has proposed banning non-compete contracts
9 in order to reduce wage suppression and stimulate the flow of workers between employers, and
10 increase competition, which could result in increased earnings for workers by $250-$290 billion
11 annually[1]; and
12
13 Whereas, The use of non-compete agreements has been extensive in the healthcare system,
14 affecting 37-45% of physicians, including those in residency and fellowship training[2,3]; and
15
16 Whereas, The elimination of non-compete contracts could lead to a reduction in consumer
17 health care costs by approximately $148 billion a year, increasing affordability and access to
18 healthcare services for patients[1]; and
19
20 Whereas, Allowing physicians to work for multiple hospitals can enhance the availability of
21 specialist coverage in a community, improving patient access to care and reducing healthcare
22 disparities; and
23
24 Whereas, Recently graduating trainees entering the workforce are especially vulnerable to the
25 negative effects of non-compete contracts, which can limit their opportunities for career
26 advancement and restrict their ability to provide care in underserved areas; and
27
28 Whereas, Although the Accreditation Council for Graduate Medical Education (ACGME)
29 currently prohibits restrictive covenants as a contingency for residents or fellows participating
30 within any GME training program, there are non-ACGME fellowship programs which require
31 trainees to sign restrictive covenants as a condition for employment; and
32
33 Whereas, During the COVID-19 pandemic physicians advocating for healthcare worker safety
34 and adequate personal protective equipment (PPE) were threatened with termination, which
35 due to non-compete clauses meant months or years of unemployment or geographic relocation;
36 and

1 Whereas, When physicians are legally restrained from terminating a contract of employment,
2 employers are not incentivized to create supportive work environment or respond to physician
3 advocacy, further contributing to physician burnout; and
4
5 Whereas, Some employers offer recruitment and retention incentives, such as sign-on bonuses,
6 student loan reimbursement, moving expenses or housing fees that become “de facto” non-
7 compete covenants because employers require these expenses to be repaid upon contract
8 termination; and
9
10 Whereas, Our AMA’s Code of Ethics E-11.2.3.1, *Restrictive Covenants*, recognizes that
11 “Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit
12 access to care” and further advises physicians not to enter agreements that “unreasonably
13 restrict a physician’s right to practice medicine for a specified period of time or in a specified
14 geographic area on termination of a contractual relationship”; and
15
16 Whereas, Current AMA policy D-383.978, *Restrictive Covenants of Large Health Care Systems,*
17 speaks to the need to “educate medical students, physicians-in-training and physicians entering
18 employment contracts with large healthcare systems on the dangers of aggressive restrictive
19 covenants”; and
20
21 Whereas, The AMA has not supported elimination or prohibition of covenants not-to-compete,
22 despite the overwhelming harm non-compete clauses bear in the current healthcare landscape
23 and has been criticized for its “noncommittal approach” that fails to protect physicians
24 (H-383.987, *Restrictive Covenants in Physician Contracts);* and
25
26 Whereas, Covenants not-to-compete are already prohibited outright in several states including
27 California, North Dakota, Oklahoma and Washington D.C; and additional states such as New
28 Hampshire, Delaware, Massachusetts and Rhode Island ban non-compete covenants
29 specifically for physicians, but they remain legal in 38 states; and
30
31 Whereas, Many national specialty and state societies supported the Federal Trade
32 Commission’s (FTC) recent proposed ban on non-compete agreements to protect employed
33 physicians but also urged FTC to include non-profit hospital employers which comprise 58% of
34 the nation’s hospitals (AHA); and
35
36 Whereas, Non-compete bans 1) allow physicians the autonomy to advocate on behalf of their
37 patients without inappropriate interference and protects the sanctity of the physician-patient
38 relationship; 2) protect patient access to care, particularly in rural and underserved areas, by
39 allowing physicians to change jobs but remain in those areas to care for their communities; and
40 3) can discourage consolidation which can lead to increased health care costs; therefore be it
41
42 RESOLVED, That our American Medical Association support policies, regulations, and
43 legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold
44 employment contracts with for-profit or non-profit hospital, hospital system, or staffing company
45 employers (New HOD Policy); and be it further

46 RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a
47 contingency of employment for any physician-in-training, regardless of the ACGME
48 accreditation status of the residency/fellowship training program (New HOD Policy), and be it
49 further

1 RESOLVED, That our AMA study and report back on current physician employment contract
2 terms and trends with recommendations to address balancing legitimate business interests of
3 physician employers while also protecting physician employment mobility and advancement,
4 competition, and patient access to care - such recommendations to include the appropriate
5 regulation or restriction of 1) Covenants not to compete in physician contracts with independent
6 physician groups that include time, scope, and geographic restrictions; and 2) De facto non-
7 compete restrictions that allow employers to recoup recruiting incentives upon contract
8 termination. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

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2. Lavetti K, Simon C, White WD. The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians∗. Kurt J. Lavetti. http://kurtlavetti.com/UIPNC_vf.pdf. Published June 29, 2018. Accessed April 18, 2023.
3. Smith, EB Ending Physician Non-compete Agreements—Time for a National Solution. *JAMA Health Forum.* 2021;2(12):e214018

RELEVANT AMA POLICY

Restrictive Covenants in Physician Contracts H-383.987
Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.
Citation: BOT Rep. 13, A-16;

Restrictive Covenants of Large Health Care Systems D-383.978
Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
Citation: Res. 026, A-19; Modified: Speakers Rep. 1, A-21

Covenants Not to Compete D-265.988
Our AMA will create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level.
Citation: BOT Rep. 06, I-20;

E-11.2.3.1 Restrictive Covenants
Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:
(a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
(b) Do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-23)

Introduced by: Arizona

Subject: Eliminate Mandatory Medicare Budget Cuts

Referred to: Reference Committee B

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1 Whereas, The 2023 Medicare payments are to cut physician pay; and
2
3 Whereas, Medicare payments to physicians have not been consistent with inflation and have
4 not increased in 20 years[1]; and
5
6 Whereas, Practice costs and consumer prices have increased during that time frame; and
7
8 Whereas, Medicare physician payments have declined 22% over the last two decades when
9 adjusted for inflation[2]; therefore be it
10
11 RESOLVED, That our American Medical Association continue to advocate for new legislation on
12 Medicare physician payment reform. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

1. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, February 2022
2. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-23)

Introduced by: Arizona

Subject: Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

Referred to: Reference Committee B

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1 Whereas, Advanced Practice Providers (APP's: PA's and NP's) have an established scope of
2 practice directly determined by the specialty of their supervisory physician and their practice
3 site; and
4
5 Whereas, Advanced Practice Providers in collaboration with their supervisory physicians
6 provide care commensurate with the specialty training and board certification of the physician;
7 and
8
9 Whereas, Currently Advanced Practice Providers do not have any established standard for a
10 residency or apprenticeship requirement or specialization process after graduation that aligns
11 them with the specialty training of their supervisory physicians; and
12
13 Whereas, This absence of specialty designation for Advanced Practice Providers creates the
14 following harms to the practice of medicine and the quality of care for our patients:
15 1. Advanced Practice Providers can completely change their professional specialty focus
16 overnight creating major training requirements and costs for the practice that hires them.
17 2. Lower income physician specialties like primary care are disproportionately impacted by
18 the frequent departure of APP's for higher income specialties.
19 3. Costly training periods for APP's can take a minimum of one year, for example, for
20 primary care based specialties.
21 4. The current "non-specialty designated" APP system creates a financially exploitative
22 system. Specialties with higher physician salaries unfairly lure away APP's from the
23 practices of lower salaried physicians. Those practices are unable to compete with
24 salaries offered by disparate higher income specialties.
25 5. Primary care practices, for example, are thus left with untenable training cost losses and
26 exponentially high turnover in an already volatile and predatory market; and
27
28 Whereas, If residency and specialty training make sense for physicians, some type of
29 established apprenticeship training program within established specialties must also make
30 sense for APP's; and
31
32 Whereas, Current severe healthcare workforce shortages in the setting of an inflationary
33 economy and reduced physician payments for our services, makes an alignment of APP salary
34 and specialty competition particularly critical; therefore be it
35
36 RESOLVED, That our American Medical Association Board of Trustees study and report back
37 at the 2023 Interim meeting on the economic impact to primary care and other lower tier income

1 medical specialties of specialty switching by Advanced Practice Providers (Directive to Take
2 Action); and be it further
3
4 RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim
5 meeting about possible options on how APP's can best be obligated to stay in a specialty tract
6 that is tied to the specialty area of their supervising physician in much the same way their
7 supervisory physicians are tied to their own specialty, with an intent for the study to look at how
8 the house of medicine can create functional barriers that begin to make specialty switching by
9 Advanced Practice Providers appropriately demanding. (Directive to Take Action)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-23)

Introduced by: Illinois

Subject: Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

Referred to: Reference Committee B

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1 Whereas, Medical records are extremely confidential records governed by the Health Insurance
2 Portability and Accountability Act of 1996 (HIPAA) and can only be disclosed under certain
3 circumstances; and
4
5 Whereas, It is recommended that any documentation that may be required in a personal injury
6 or breach of contract dispute is retained for as long as necessary. "As long as necessary" will
7 depend on the relevant statute of limitations in force in the state. In many cases, statutes of
8 limitation are longer than any HIPAA record retention periods; and
9
10 Whereas, The filing of a civil lawsuit provides the mechanism for the issuance of subpoenas for
11 witnesses and subpoenas duces tecum to produce documents that often involve medical
12 records; and
13
14 Whereas, The Circuit Court of Cook County amended its Health Insurance Portability and
15 Accountability Act (HIPAA) Protective Order following the Illinois Supreme Court's recent
16 determination of an insurer's obligations with a plaintiff's protected health information (PHI). In
17 short, PHI obtained by insurance companies during litigation cannot be used outside the
18 litigation context, and it must be returned/destroyed at its conclusion. (*See Haage v. Zavala*,
19 2021 IL 125918); and
20
21 Whereas, The amended HIPAA Protective Order requires return or destruction of all records
22 within 60 days of the close of the case. This prohibits parties, counsel, *and the parties'*
23 *insurers* from using PHI for any purpose other than the litigation in which the order was entered;
24 and
25
26 Whereas, The American Bar Association is generally silent regarding attorney's retention of
27 medical records after the case is adjudicated; and
28
29 Whereas, Courts have required controlled expert witnesses to produce personal financial
30 records, including federal 1099 tax forms related to legal work as well as personal income tax
31 returns, even when they include information concerning the expert's spouse; and
32
33 Whereas, In *Grant v. Rancour*, 2020 IL App (2d) 190802 (June 12, 2020), the court stated that:
34 "Opposing parties may cross-examine an expert witness about the amount and percentage of
35 his or her income generated as an expert witness, the frequency with which he or she testifies,
36 and the frequency with which he or she testifies for a particular side."; and
37
38 Whereas, Personal tax returns of medical experts obtained by attorneys should be afforded
39 similar HIPPA type protections after the close of the case; and

1 Whereas, Attorney's prolonged retention of these confidential and private documents can only
2 be utilized in an adversarial intent; therefore be it further
3
4 RESOLVED, That our American Medical Association advocate that attorney requests for
5 controlled medical expert personal tax returns should be limited to 1099-MISC forms
6 (miscellaneous income) and that entire personal tax returns (including spouse's) should not be
7 forced by the court to be disclosed (Directive to Take Action); and be it further
8
9 RESOLVED, That our AMA advocate through legislative or other relevant means the proper
10 destruction by attorneys of medical records (as suggested by *Haage v. Zavala*, 2021 IL 125918)
11 and medical expert's personal tax returns within sixty days of the close of the case. (Directive to
12 Take Action)

Fiscal Note: TBD

Received: 5/5/23

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2. https://www.cdc.gov/phlp/publications/topic/hipaa.html
3. https://www.hipaajournal.com/hipaa-retention-requirements/
4. Haage v. Zavala, 2021 IL 125918.
5. https://www.americanbar.org/
6. https://www.clausen.com/cook-county-uses-hipaa-to-further-limit-discovery-and-use-of-litigants-medical-records/
7. Grant v. Rancour, 2020 IL App (2d) 190802 (June 12, 2020)

RELEVANT AMA POLICY

Expert Witness Testimony H-265.994
(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.
(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.
(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:
(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.
(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.
(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either

plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.
Citation: (Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05; Reaffirmed: BOT Rep. 10, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-23)

Introduced by: Illinois

Subject: Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents

Referred to: Reference Committee B

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1 Whereas, The majority of physicians reported that prescription drug monitoring programs
2 (PDMPs) improved their opioid prescribing by decreasing the amount administered and
3 increasing comfort in prescribing[2]; and
4
5 Whereas, A systematic review showed a significant correlation between appropriate utilization
6 of PDMPs and reduced rate of opioid abuse[3]; and
7
8 Whereas, Expanding accessibility of PDMPs may further amplify PDMPs effectiveness and
9 allow the clinical care team to be more efficient, particularly in an academic setting[4]; and
10
11 Whereas, Accessibility of PDMPs to front-line health care workers allows its utilization as a
12 screening tool instead of postemptive verification[4]; and
13
14 Whereas, Deficits of the PDMPs include ineffective data utilization, such as resistance to use of
15 systems by providers experiencing an increased workload[2,5]; and
16
17 Whereas, Medical and pharmaceutical students are afforded fewer patient loads and more
18 patient-centered time than their resident and attending physician team members, allowing more
19 focus on a patient's nuanced prescription history; and
20
21 Whereas, Medical and pharmaceutical students have access to patient health information
22 through electronic health record (EHR) in their clinical years, providing access to PDMPs will
23 impart comprehensive job training in their role as future physicians; and
24
25 Whereas, Our American Medical Association has existing policy (H-95.939, *Development and*
26 *Promotion of Single National Prescription Drug Monitoring Program*) in support of a physician's
27 ability to designate a delegate to check information on the Prescription Drug Monitor Program,
28 depending on state law; and
29
30 Whereas, Our AMA acknowledges that Prescription Drug Monitoring Program data is health
31 information and promotes medical school training that incorporates safe prescribing practices,
32 safe medication storage and disposal practices, and functional assessment of patients with
33 chronic conditions in order for the future generation of physicians to contribute to positive
34 solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths
35 (H-95.945, *Prescription Drug Diversion, Misuse and Addiction*); therefore be it
36
37 RESOLVED, That our American Medical Association amend Policy H-95.945, *Prescription Drug*
38 *Diversion, Misuse and Addiction*, to include prescription drug monitoring program (PDMP)

1 viewing access as a mainstay of appropriate and comprehensive medical training for clinical
2 medical students and residents. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

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RELEVANT AMA POLICY

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939
Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.
Citation: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-23)

Introduced by: Illinois

Subject: Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

Referred to: Reference Committee B

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1 Whereas, Peer to peer reviews, the purpose of which is to determine if a patient should have a
2 certain procedure, frequently involve physicians that are not of the same specialty as the
3 requesting physician; and
4
5 Whereas, Denials of necessary procedures benefiting the patient unfortunately occur during
6 peer to peer reviews where the physician reviewer is not of the same specialty as the physician
7 recommending a particular procedure; therefore be it
8
9 RESOLVED, That our American Medical Association adopt policy in support of and cause to be
10 introduced legislation requiring any peer to peer review require a physician from the same
11 specialty as the physician requesting a procedure for their patient, be involved in the peer to
12 peer phone call and decision process. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

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;

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;

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;

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;

Medical Necessity Determinations H-320.995
(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.
(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.
Citation: CMS Rep. L, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation and Reaffirmed: Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmation: A-18; Reaffirmation: A-22;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-23)

Introduced by: Illinois

Subject: Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

Referred to: Reference Committee B

Whereas, The use of expert witnesses has become an integral and indispensable aspect of American litigation, and it is often the side with the best expert who wins the day; and

Whereas, Federal Rule of Evidence 702 provides: *Testimony by Expert Witnesses: A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case;* and

Whereas, Medical experts make up about 40% of testifying experts at the federal level; and

Whereas, There are generally two standards that govern admissibility of expert testimony: The Frye Standard (1923) and the Daubert Standard (1993); and

Whereas, The Frye standard or Frye test (or general acceptance test as it became to be known) is a test to determine the admissibility of scientific evidence providing that expert opinion based on a scientific technique is admissible only where the technique is generally accepted as reliable in the relevant scientific community. A court applying the Frye standard must determine whether or not the method by which that evidence was obtained was generally accepted by experts in the particular field in which it belongs; and

Whereas, Under the Daubert standard, the factors that may be considered in determining whether the methodology is valid are: (1) whether the theory or technique in question can be and has been tested; (2) whether it has been subjected to peer review and publication; (3) its known or potential error rate; (4) the existence and maintenance of standards controlling its operation; and (5) whether it has attracted widespread acceptance within a relevant scientific community; and

Whereas, The United States Supreme Court further clarified that an expert must "employ in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field;" and

Whereas, In most jurisdictions (and all federal courts), the Frye standard has been superseded by the Daubert standard. States still following Frye include California, Illinois, Maryland, Minnesota, New Jersey, New York, Pennsylvania, and Washington (Florida switched in May 2019); and

1 Whereas, In Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999), the U.S. Supreme Court
2 extended its Daubert reasoning to all expert testimony, not simply that which was considered
3 "scientific;" and
4
5 Whereas, The second sentence of Illinois Rule of Evidence 702 enunciates the core principles
6 of the Frye test for admissibility of scientific evidence as set forth in Donaldson v. Central Illinois
7 Public Service Co., 767 N.E.2d 314 (Ill. 2002); and
8
9 Whereas, A court applying the traditional (Frye) standard of care is less interested in the
10 methodology underlying the expert's opinion and more interested in the experience and
11 education of the expert; and
12
13 Whereas, By applying a Daubert analysis to an expert's testimony on the standard of care, the
14 testimony becomes a scientifically based testimony rather than an expert's notion of what is
15 common practice in the medical profession; and
16
17 Whereas, Daubert challenges do present an opportunity to keep frivolous testimony out of a
18 trial; and
19
20 Whereas, Using a dataset of all medical malpractice payouts reported between 2004 and 2018
21 to the U.S. Department of Health and Human Services, using a difference-in-differences
22 approach to examine the effect of adopting the Daubert standard in state courts that previously
23 adhered to the Frye standard, it was found that adopting Daubert is associated with a modest
24 increase in settlement amounts (7.44% or $25,578) and a decrease in the filing rate (.44 fewer
25 claims filed per 100,000; mean filing rate in Daubert and Frye jurisdictions was 4.8 and 6.1,
26 respectively; This result is statistically significant at the 5% level); and
27
28 Whereas, The Daubert standard is a higher standard than the Frye standard for admissibility of
29 expert witness testimony; therefore be it
30
31 RESOLVED, That our American Medical Association advocate through legislative or other
32 relevant means the use of the Daubert Standard to replace the Frye Standard for Expert
33 Witness Testimony. (Directive to Take Action)

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

Received: 5/5/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-23)

Introduced by: American Association of Public Health Physicians

Subject: Recidivism

Referred to: Reference Committee B

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1 Whereas, Recidivism has constantly risen and is now 44% of those released from a correctional
2 facility[1]; and
3
4 Whereas, There are many factors causing recidivism including untreated mental health
5 disorders, untreated substance use disorders, homelessness, and inadequate discharge
6 planning by the correctional facility[1,2]; and
7
8 Whereas, These factors result from insufficient personnel to treat mental health conditions
9 during persons' incarceration; insufficient mental health care community workers; and
10 insufficient substance use disorder treatment programs in correctional facilities[1]; and
11
12 Whereas, There are insufficient mental health and drug rehabilitation programs and counselors
13 in the community[1]; and
14
15 Whereas, There is inadequate low-cost housing for persons recently released from a
16 correctional facility[2]; and
17
18 Whereas, There are insufficient shelters and rehabilitation facilities in the community; and
19
20 Whereas, With proper post-release medical care, recidivism can be reduced; therefore be it
21
22 RESOLVED, That our American Medical Association advocate and encourage federal, state,
23 and local legislators and officials to increase the number of community mental health facilities to
24 meet the need of indigent, homeless, and released previously incarcerated persons (Directive to
25 Take Action); and be it further
26
27 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and
28 officials to increase the number of community drug rehabilitation facilities to meet the needs of
29 indigent, homeless, and released previously incarcerated persons (Directive to Take Action);
30 and be it further
31
32 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and
33 officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated
34 persons to live (Directive to Take Action); and be it further
35
36 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and
37 officials to ensure that correctional facilities have adequate well-trained personnel who can
38 ensure that those incarcerated persons released from their facility are able to immediately have
39 access to mental health, drug and residential rehabilitation facilities at an appropriate level
40 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and
2 officials to advocate prompt reinstatement in governmental medical programs and insurance for
3 those being released from incarceration facilities. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

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;

Juvenile Justice System Reform H-60.919

Our AMA:
1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance' policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to

public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
9. Will create a policy to establish minimal age of 14 years for juvenile justice jurisdiction in the United States.
10. Will develop model legislation to establish minimal age of 14 for juvenile justice jurisdiction in the United States.
Citation: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16; Appended: Res. 905, I-22;

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
Citation: CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18;

Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976
1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders.
2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes.
3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services.
Citation: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

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;

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;

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
Citation: A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19;

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;
Physicians, Psychotherapy and Mental Health Care H-345.996
Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public.
Citation: Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

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;

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;

Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974
1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders.
Citation: Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmation A-15; Modified: Res. 113, A-16; Modified: Res. 216, I-22;

Increased Funding for Substance Use Disorder Treatment H-95.973
Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.
Citation: Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Referral of Patients to Substance Use Disorder Treatment Programs H-95.991
Our AMA urges its members to acquaint themselves with the various substance use disorder treatment programs available for the medical treatment of alcohol and drug use and, where appropriate, to refer their patients to them promptly.
Citation: Res. 31, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

Drug Abuse in the United States - Treatment Effectiveness And Capacity - A Preliminary Report H-95.969
Given the need throughout the health care delivery field for more effective and efficient forms of treatment, it is important to investigate the potential for better patient-treatment matching in treating alcohol and drug abusers. Researchers usually try to isolate each element of treatment in order to study it scientifically. In practice, however, several treatment approaches are typically used simultaneously or sequentially. In general, there have been too few well-controlled studies of combined interventions to permit final conclusions about their overall effectiveness in alcohol and drug abuse patients. The available findings are somewhat unimpressive, however, given the scope and intensity of the many combined treatment programs. One reason for the lack of impressive findings may have to do with patient characteristics which determine the amount of change which will occur with any treatment, and perhaps the degree to which additional treatment will result in additional measurable change. In highly motivated good-prognosis patients, for example, one well-chosen intervention - or even standard treatment - may produce maximal amounts of change, making the impact of additional interventions unmeasurable and, by implication, unnecessary. In poor-prognosis patients, on the other hand, the overall amount of change possible may be very limited, making a significant difference between one or many interventions difficult to demonstrate. Finding patient variables (i.e., prior drinking pattern, psychiatric morbidity) that are strongly predictive of treatment outcome may help identify patients expected to benefit least - and most - from multiple interventions. The AMA believes immediate attention should be given to all of these areas of urgently needed action, and commits itself to continued participation in the formulation, dissemination, and evaluation of the national responses to the problems of alcohol and drug abuse.
Citation: BOT Rep. Y, A-90; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

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;

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966
Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.
Citation: Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res. 203, A-16;

Survey of Addiction Treatment Centers' Availability H-95.926
Our AMA: (1) encourages the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSAs treatment locators; (2) encourages physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSAs treatment locators; and (3) encourages SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.
Citation: CMS Rep. 04, A-17;

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;

Increased Funding for Drug-Related Programs H-95.980
The AMA supports the expansion of those drug rehabilitation programs which provide an environment for medical and other professional counseling, education and behavior change, and voluntary HIV testing for persons at risk for HIV.
Citation: Res. 35, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Biosimilar/Interchangeable Terminology

Referred to: Reference Committee B

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1 Whereas, Biosimilars are a type of biologic medication that is safe and effective for treating
2 many illnesses; and
3
4 Whereas, A biosimilar and its original biologic have no clinically meaningful differences in terms
5 of quality, safety, and efficacy; and
6
7 Whereas, Biosimilars and biologics have the same treatment risks and benefits[1]; and
8
9 Whereas, Biosimilars may be available at a lower cost than the original biologic reference
10 product and studies show that savings improve when biosimilars are used in place of reference
11 biologics during the treatment of cancer malignancies, resulting in savings to the Medicare
12 program and decreased out-of-pocket costs for patients; and
13
14 Whereas, An interchangeable product is not superior in quality to a biosimilar and would have to
15 meet the same regulatory requirements as a biosimilar; and
16
17 Whereas, Interchangeability is simply a legislative term that has created confusion about the
18 inherent lack of clinically meaningful difference among biosimilars; and
19
20 Whereas, If a biosimilar is equivalent in structure, function, safety, and efficacy to the reference
21 product, by definition the two are interchangeable; and
22
23 Whereas, Despite the Food and Drug Administration's (FDA) efforts to provide clarity on the
24 meaning of "interchangeable" (a new legislative term), including the release of guidance on
25 interchangeability, confusion and misinformation remain; and
26
27 Whereas, By creating a divide between a biosimilar and an interchangeable biosimilar for
28 regulatory purposes at the pharmacy level, the United States further exacerbates clinician and
29 patient education and access barriers[2]; therefore be it
30
31 RESOLVED, That our American Medical Association repeal policy H-125.976, *Biosimilar*
32 *Interchangeability Pathway* (Rescind HOD Policy); and be it further
33
34 RESOLVED, That our AMA advocate for state and federal laws and regulations that support
35 patient and physician choice of biosimilars and remove the "interchangeable" designation from
36 the FDA's regulatory framework. (Directive to Take Action)

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

Received: 5/10/23

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2. Gladys Rodriguez et. al, ASCO Policy Statement on Biosimilar and Interchangeable Products in Oncology. *JCO Oncology Practice.* April 07, 2023. https://ascopubs.org/doi/pdf/10.1200/OP.22.00783?role=tab

RELEVANT AMA POLICY

Biosimilar Interchangeability Pathway H-125.976
Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance Considerations in Demonstrating Interchangeability With a Reference Productwith all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients.
Citation: Res. 523, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246
(A-23)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Modification of CMS Interpretation of Stark Law

Referred to: Reference Committee B

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1 Whereas, The physician self-referral law, commonly referred to as the Stark Law (42 U.S.C.
2 1395nn):
3 1. Prohibits a physician from making referrals for certain designated health services
4 payable by Medicare to an entity with which he or she (or an immediate family member)
5 has a financial relationship (ownership, investment, or compensation), unless an
6 exception applies;
7 2. Prohibits the entity from presenting or causing to be presented claims to Medicare (or
8 billing another individual, entity, or third-party payer) for those referred services; and
9 3. Establishes a number of specific exceptions and grants the Secretary the authority to
10 create regulatory exceptions for financial relationships that do not pose a risk of program
11 or patient abuse[1]; and
12
13 Whereas, Exceptions under the Stark law include in-office ancillary services so that physicians
14 can furnish designated health services to practice patients; and
15
16 Whereas, Medically integrated pharmacy services increase patient adherence and allow
17 physicians to trust that their patients receive intended drug treatment with appropriate
18 instructions[2,3]; and
19
20 Whereas, Many physician practices have in-office pharmacies as part of the delivery of health
21 care; and
22
23 Whereas, Physician office pharmacies have been able to have a trusted surrogate pick up
24 prescriptions on behalf of a patient when the patient is unable to come into the office for
25 whatever reason, including illness or lack of transportation; and
26
27 Whereas, Physician office pharmacies have been able to mail or otherwise send a prescription
28 securely to a patient when the patient is unable to come into the office for whatever reason,
29 including illness or lack of transportation; and
30
31 Whereas, A set of frequently asked questions (FAQs) issued by the Center for Medicare &
32 Medicaid Services (CMS)[4] states that the delivery of a medicine to a patient using the Postal
33 Service, a commercial package service, or by a trusted surrogate violates the in-office exception
34 of the Stark Law, because that the drug was not dispensed to the patient in the physician office
35 because the patient was not physically present; and
36
37 Whereas, CMS guidance may have a negative impact on timely access to treatment for patients
38 and may increase the administrative burden for physicians; therefore be it

1 RESOLVED, That our American Medical Association request that the Center for Medicare &
2 Medicaid Services retract the determination that delivery of medicine to a patient using the
3 Postal Service, a commercial package service, or by a trusted surrogate violates the in-office
4 exception of the Stark Law (Directive to Take Action); and be it further
5
6 RESOLVED, That our AMA advocate for legislation to clarify that a surrogate may deliver
7 medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law
8 if the Center for Medicare & Medicaid Services does not change its position on disallowing the
9 delivery of medicine to a patient using the Postal Service or a commercial package service.
10 (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Physician Ownership and Referral for Imaging Services D-270.995
Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.
Citation: (Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: BOT Rep. 10, A-15; Reaffirmed in lieu of Res. 213, A-15)

Access to In-Office Administered Drugs H-330.884
1. Our American Medical Association will advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved.
2. Our AMA will work with the Center for Medicare & Medicaid Services, The Joint Commission, America's Health Insurance Plans, Federation of State Medical Boards, National Association of Boards of Pharmacy, and other involved stakeholders to improve and support patient access to in-office administered drugs.
3. Our AMA will advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug.
Citation: Res. 702, A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: A-18; Reaffirmation: I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247
(A-23)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Assessing the Potentially Dangerous Intersection Between AI and Misinformation

Referred to: Reference Committee B

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1 Whereas, Our American Medical Association has extensive policy on Augmented Intelligence
2 (AI), including H-480.939, H-480.940, 11.2.1, H-295.857; and
3
4 Whereas, In AMA policy H-480.939, *Augmented Intelligence in Health Care,* "our AMA will
5 advocate that
6 1. Oversight and regulation of health care AI systems must be based on risk of harm and
7 benefit accounting for a host of factors, including but not limited to: intended and reasonably
8 expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI
9 system methods; level of automation; transparency; and, conditions of deployment.
10 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best
11 positioned to know the AI system risks and best positioned to avert or mitigate harm do so
12 through design, development, validation, and implementation. Our AMA will further
13 advocate:
14 a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual
15 or entity issuing the mandate must be assigned all applicable liability.
16 b. Developers of autonomous AI systems with clinical applications (screening, diagnosis,
17 treatment) are in the best position to manage issues of liability arising directly from system
18 failure or misdiagnosis and must accept this liability with measures such as maintaining
19 appropriate medical liability insurance and in their agreements with users.
20 c. Health care AI systems that are subject to non-disclosure agreements concerning flaws,
21 malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and
22 the party initiating or enforcing the gag clause assumes liability for any harm"; and
23
24 Whereas, In AMA policy H-480-940, *Augmented Intelligence in Health Care*, "our AMA has a
25 unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine
26 benefits patients, physicians, and the health care community. To that end our AMA will seek to:
27 1. Leverage its ongoing engagement in digital health and other priority areas for improving
28 patient outcomes and physicians' professional satisfaction to help set priorities for health
29 care AI.
30 2. Identify opportunities to integrate the perspective of practicing physicians into the
31 development, design, validation, and implementation of health care AI.
32 3. Promote development of thoughtfully designed, high-quality, clinically validated health
33 care AI that:
34 a. is designed and evaluated in keeping with best practices in user-centered design,
35 particularly for physicians and other members of the health care team;
36 b. is transparent;
37 c. conforms to leading standards for reproducibility;

1 d. identifies and takes steps to address bias and avoids introducing or exacerbating health
2 care disparities including when testing or deploying new AI tools on vulnerable populations;
3 and
4 e. safeguards patients' and other individuals' privacy interests and preserves the security
5 and integrity of personal information.
6 4. Encourage education for patients, physicians, medical students, other health care
7 professionals, and health administrators to promote greater understanding of the promises
8 and limitations of health care AI.
9 5. Explore the legal implications of health care AI, such as issues of liability or intellectual
10 property, and advocate for appropriate professional and governmental oversight for safe,
11 effective, and equitable use of and access to health care AI"; and
12
13 Whereas, In AMA policy 11.2.1, "Clinical prediction models, decision support tools, and similar
14 tools such as those that rely on AI technology must rest on the highest-quality data and be
15 independently validated in relevantly similar populations of patients and care settings;" and
16
17 Whereas, AI may have the potential to augment medical and public health misinformation; and
18
19 Whereas, AI may have the potential to propagate negative anonymous cyberspace evaluations
20 of physicians; therefore be it
21
22 RESOLVED, That our American Medical Association study the potential for AI to augment
23 medical and public health misinformation, as well as the potential to augment cyber-libel, cyber-
24 slander, cyber-bullying, and dissemination of internet misinformation about physicians; and that
25 our AMA propose appropriate state and federal regulations and legislative remedies, with a
26 report back at the 2023 Annual meeting. (Directive to Take Action)

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

Received: 5/10/23

RELEVANT AMA POLICY

Anonymous Cyberspace Evaluations of Physicians D-478.980
Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.
Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)

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;

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;

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
Citation: CME Rep. 04, A-19;

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 patientsand other individualsprivacy 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;

E.11.2.1 Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should:

(a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
(c) Ensure that all such tools:
    (i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(d) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(f) Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

Issued: 2016; Amended: 2021; Amended: 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248
(A-23)

Introduced by: Indiana

Subject: Supervised Consumption Sites

Referred to: Reference Committee B

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1 Whereas, Supervised Consumption Sites (also known as overdose prevention sites, safe
2 injection sites, harm reduction centers, etc.), are sites where people can use controlled
3 substances while being monitored by staff; and
4
5 Whereas, Such government-sanctioned sites are now operating in New York City, D.B.A. Insite,
6 North America's first legal supervised sites having more than 100 sites around the world, and
7 Vancouver's Insite averaged 312 injection room visits per day in 2019; and
8
9 Whereas, Only a few such sites now operate in the U.S. and may soon expand without much
10 knowledge or concern by the medical community; and
11
12 Whereas, It is reported that the U.S. Department of Justice is evaluating the establishment of
13 such sites and conferring with regulators about appropriate guardrails; and
14
15 Whereas, AMA policy H-95.925, *Pilot Implementation of Supervised Injection Facilities,* supports
16 the development and implementation of "pilot supervised injection facilities", but the current
17 preferred terms for these sites is "overdose prevention site" or "harm reduction center";
18 therefore be it
19
20 RESOLVED, That our American Medical Association seek information and consider policy and
21 legislation regarding the federal legalization of overdose prevention sites (Directive to Take
22 Action); and be it further
23
24 RESOLVED, That our AMA amend policy H-95.925, *Pilot Implementation of Supervised*
25 *Injection Facilities,* to replace the references to "supervised injection facilities" with "overdose
26 prevention sites". (Modify Current HOD Policy)

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

Received: 5/10/23

RELEVANT AMA POLICY

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: 249
(A-23)

Introduced by: Indiana

Subject: Restrictions on Social Media Promotion of Drugs

Referred to: Reference Committee B

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1 Whereas, Many of our youth have access and exposure to social media outlets that have great
2 potential to influence our young people regarding drugs; and
3
4 Whereas, A recent study published in the Journal of Studies on Alcohol and Drug reported on
5 popular alcohol videos on the social networking site TikTok and noted - 98% of the videos
6 expressed pro-alcohol sentiment; nearly half were guide videos demonstrating drink recipes;
7 61% depicted consuming multiple drinks quickly; 69% conveyed positive experiences; 55%
8 contained humor; nearly half associated alcohol with camaraderie but only 4% of the videos
9 depicted alcohol with negative associations; and
10
11 Whereas, Similar results could be anticipated with social media networks with other drugs;
12 therefore be it
13
14 RESOLVED, That our American Medical Association seek policy and legislation that would limit
15 social media's promotion and dissemination of corporate advertisement on usage of commercial
16 and illicit drugs to our youth. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250
(A-23)

Introduced by: Indiana

Subject: Medicare Budget Neutrality

Referred to: Reference Committee B

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1 Whereas, Medicare physician payments have not had regular positive updates; and
2
3 Whereas, Medical practice expenses have gone up significantly every year; and
4
5 Whereas, Medicare physician payments have lagged behind and have not kept up with inflation
6 and practice costs; and
7
8 Whereas, Every year physicians must advocate to prevent a Medicare payment cut; and
9
10 Whereas, Other health care entities like the hospitals and insurance companies are not subject
11 to budget neutrality; and
12
13 Whereas, The physician payments are subject to budget neutrality, which results in a
14 threatened pay cut every year; therefore be it
15
16 RESOLVED, That our American Medical Association reaffirm its position supporting removal of
17 budget neutrality for Medicare physician payments, which would result in regular positive
18 updates for physicians so that the payments can keep up with inflation and practice expenses.
19 (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251
(A-23)

Introduced by: Maryland

Subject: Federal Government Oversight of Augmented Intelligence

Referred to: Reference Committee B

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1 Whereas, Safety of patients is of physicians' utmost concern; and
2
3 Whereas, The applications for augmented intelligence have grown exponentially in the last
4 decade; and
5
6 Whereas, There may be positive applications for improved human health such as in PTSD or
7 pain management; and
8
9 Whereas, Without appropriate oversight, the developing applications could also have
10 detrimental impacts to human health; and
11
12 Whereas, The U.S. Food and Drug Administration (FDA) protects public health by
13 regulating human drugs and biological products, animal drugs, medical devices, tobacco
14 products, food (including animal food), cosmetics, and electronic products that emit radiation;
15 and
16
17 Whereas, The U.S. Department of Agriculture (USDA) protects public health by regulating food,
18 agriculture, natural resources, rural development, nutrition, and related issues based on public
19 policy, the best available science, and effective management; and
20
21 Whereas, There is no federal agency at present which is charged with oversight of augmented
22 intelligence and social media and their effect on health; therefore be it
23
24 RESOLVED, That our American Medical Association study and develop recommendations on
25 how to best protect public health by regulation and oversight of the development and
26 implementation of augmented intelligence and its applications in the healthcare arena. (Directive
27 to Take Action)

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

Received: 5/1/23

RELEVANT AMA POLICY

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;

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 physiciansprofessional 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 patientsand other individualsprivacy 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 Medical Education H-295.857
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
Citation: CME Rep. 04, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252
(A-23)

Introduced by: Maryland

Subject: Strengthening Patient Privacy

Referred to: Reference Committee B

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Privacy Rule in order to protect the use and transmission of "individually identifiable health information" and now sets the federal guideline and industry-wide standard for privacy and security of protected health information (PHI)[1]; and

Whereas, In recognition of the increasing adoption and potential utility of health information in life sciences research, policy assessment, health operations studies, and more, the Privacy Rule permits a covered entity to use and disclose health information if it is de-identified or does not provide a reasonable basis to identify an individual[1]; and

Whereas, Since federal HIPAA regulations do not regulate de-identified health information as it is not considered PHI, thereby allowing for its unrestricted use and distribution by covered entities[2]; and

Whereas, A systematic literature review revealed that anonymization of PHI does not eliminate the risk data re-identification risk and that different de-identification techniques have different re-identification risks[3]; and

Whereas, Re-identification of de-identified datasets is possible and third party data brokers such as McKinsey have been shown to leverage complex algorithms and data triangulation in order to re-identify patient data without ever having documented consent from the individuals[4]; and

Whereas, Sweeney demonstrated that publicly and semi-publicly available health data from various agencies including the Agency for Healthcare Research and Quality, when linked to publicly available data from the US census summary, could potentially allow for re-identification of all unique hospitalized patients, although risk of re-identification varied widely depending on the identifiers studied[5]; and

Whereas, Current de-identification practices of prescription records in Canada, similar to ones in the U.S., were found to have a high likelihood of re-identification with other publicly available information if stronger de-identification measures were not implemented[6]; and

Whereas, A machine learning algorithm successfully reidentified 85.6% of adults' physical activity data and demographic to individual-specific health record numbers with previously recorded physical activity data[7]; and

Whereas, The previously outlined information highlights the growing concerns of re-identification of patient's protected health information using de-identified datasets and publicly available information[9,10]; and

1 Whereas, AMA Principles of Medical Ethics 3.1.1, *Privacy in Health Care*, calls upon physicians
2 to "protect patient privacy in all settings to the greatest extent possible" and AMA policy H-
3 480.940, *Augmented Intelligence in Health Care,* calls upon the AMA to “safeguards patients’
4 and other individuals’ privacy interests and preserves the security and integrity of personal
5 information” in the context of AI; therefore be it
6
7 RESOLVED, That our American Medical Association study the modern threats to patient
8 privacy, especially in the context of augmented intelligence, and generate recommendations to
9 guide AMA advocacy in this area for the betterment of patient rights. (Directive to Take Action)

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

Received: 5/1/23

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RELEVANT AMA POLICY

3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient’s privacy must be balanced against other factors.

(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.

(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 253
(A-23)

Introduced by: New York

Subject: Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

Referred to: Reference Committee B

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1 Whereas, Physicians provide a great deal of work outside the tradition patient visit, including
2 asynchronous remote care – such as phone calls, coordination of care with subspecialists and
3 pharmacists, electronic messaging, and review of laboratory data (outside of face to face and
4 remote visit); and
5
6 Whereas, The volume of asynchronous remote work continues to increase, and was
7 accelerated in 2020-2022 during the COVID-19 pandemic[1]; and
8
9 Whereas, Uncompensated work is a significant contributor to physician burnout and a driver of
10 the loss of primary care workforce and shortages in care[1,2]; and
11
12 Whereas, Access to care coordination is greatly impacted by social determinants of health, and
13 disparities or inequities exist in patient access to care coordination[3,4]; and
14
15 Whereas, Care coordination by physicians involves frequent and ongoing contact with home
16 health and care management services, usually on days other than the actual clinical office visit,
17 and using separate electronic systems outside of the physician's electronic health record[4-6];
18 and
19
20 Whereas, The Centers for Medicare & Medicaid Services (CMS) and private insurers have
21 reimbursed for some aspects of care coordination, but these reimbursements are likely to end
22 with, or shortly after, the end of the COVID-19 public health emergency declaration[7]; therefore
23 be it
24
25 RESOLVED, That our American Medical Association create a policy stating that payors should
26 compensate physicians for asynchronous (outside the day of a patient visit) non-visit or remote
27 care, such phone calls, electronic messaging, and review of laboratory data (New HOD Policy);
28 and be it further
29
30 RESOLVED, That our AMA advocate for expansion of Current Procedural Terminology (CPT)
31 codes 99441-99445 into telemedicine parity law, that will include reimbursement similar to other
32 CPT codes. (Directive to Take Action)

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

Received: 5/10/23

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6. https://revcycleintelligence.com/news/ama-prior-authorization-creates-physician-burden-patient-care-delays

RELEVANT AMA POLICY

Evolving Impact of Telemedicine H-480.974

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.
Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 254
(A-23)

Introduced by: American College of Surgeons, American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Orthopaedic Surgeons, American Academy of Ophthalmology, American Society of Plastic Surgeons

Subject: Eliminating the Party Statement Exception in Quality Assurance Proceedings

Referred to: Reference Committee B

---

1 Whereas, Quality Assurance (QA) is an essential, legally required process for the practice of
2 surgery and medicine; and
3
4 Whereas, Proceedings and records from QA meetings, including Morbidity and Mortality
5 conferences, have been protected from discovery (QAP; QA Privilege) for nearly 50 years by
6 provisions in the Education Law (§ 6527(3)) and the Public Health Law (§2805-m(2)); and
7
8 Whereas, QA meetings allow physicians to identify best practices and improve the delivery of
9 health care services; and
10
11 Whereas, Comments made during a QA meeting by a person who is a named party in a
12 malpractice case may be discoverable and do not benefit from the same protections (known as
13 a *party-statement exception, PSE);* and
14
15 Whereas, A recent legal case, Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd Dept,
16 2021), has challenged the quality-assurance privilege in committee meeting minutes or
17 materials in which a speaker is not identified; and
18
19 Whereas, The recent decision in Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd
20 Dept, 2021) sets a new precedent of discoverability of QA meeting minutes when each speaker
21 in a QA meeting fails to be identified; and
22
23 Whereas, New York physicians or institutions currently seeking to assert a QA privilege now
24 have the burden of demonstrating that the QA committee meeting minutes were not party
25 statements subject to disclosure; and
26
27 Whereas, In response to the decision of this case and the PSE, professional organizations
28 representing hospitals have suggested limiting the involvement of named parties in QA efforts;
29 and
30
31 Whereas, In response to the decision of this case and the PSE, a growing number of New York
32 medical centers have limited the involvement of named parties in QA efforts; and
33
34 Whereas, Widespread knowledge of the recent judicial interpretation of the PSE discourages
35 open, transparent reporting and discussion of opportunities for improvement in patient care; and
36
37 Whereas, In response to diminished QA proceedings, the educational and performance
38 improvement value of QA conferences is eroding; and

1 Whereas, The PSE creates inappropriate adverse incentives for plaintiffs to name residents,
2 departmental leaders and QA officers as parties to legal proceedings for the sole purpose of
3 discovery; therefore be it
4
5 RESOLVED, That our American Medical Association reaffirm the importance of meaningful
6 Quality Assurance proceedings that are unhindered by legal discovery concerns (New HOD
7 Policy); and be it further
8
9 RESOLVED, That our AMA strongly support and advocate for eliminating the Party Statement
10 Exception to confidentiality at Quality Assurance meetings in all applicable laws. (Directive to
11 Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

REFERENCES

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 255
(A-23)

Introduced by: Georgia

Subject: Correctional Medicine

Referred to: Reference Committee B

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1 Whereas, Detained and/or incarcerated patients have the right to medical neutrality from their
2 treating physician regardless of their status as a detained or incarcerated person[1]; and
3
4 Whereas, Detained and/or incarcerated persons have the right to speak with their provider
5 confidentially[1]; and
6
7 Whereas, Detained and/or incarcerated persons have the right to removal of physical restraints
8 for the purpose of a physical exam at the discretion of the treating physician[3]; and
9
10 Whereas, Detained and/or incarcerated persons have the right to medical care at a facility that
11 has a protocol for and supports ongoing quality improvement of medical care for the
12 incarcerated patient[1]; and
13
14 Whereas, Detained and/or incarcerated persons have the right to privacy and protection from
15 inquiry regarding charges, conviction, or duration of sentence unless immediately pertinent to
16 patient care[1]; and
17
18 Whereas, Detained and/or incarcerated persons have the right to informed consent; to be
19 adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans
20 with respect to educational status and literacy as necessary[1]; and
21
22 Whereas, Detained and/or incarcerated persons have the right to refuse care, diagnostic
23 testing, nutrition, laboratory studies, medications, and procedures, for as long as the patient
24 has medical decision making capacity as deemed by the treating physician or is not at
25 immediate risk of harm to self or others[4]; and
26
27 Whereas, Detained and/or incarcerated persons have the right to timely administration of all
28 interventions and necessary consultations while in the emergency department as deemed by
29 the attending physician[1]; and
30
31 Whereas, Detained and/or incarcerated persons have the right to make their healthcare
32 decisions independent of law enforcement officials when competent, and to appoint an
33 appropriate surrogate medical decision-maker in the event they become incompetent. Wardens,
34 sheriffs, guards, police officers, prison administrators, and other law enforcement officials are
35 not eligible medical decision-makers[2]; and
36
37 Whereas, Detained and/or incarcerated persons have the right to consultation by their medical
38 decision-maker according to state laws regardless of the policies of law enforcement or carceral
39 institutions[1]; now therefore be it

1 RESOLVED, That our American Medical Association work with interested parties and key stake
2 holders, including the American College of Emergency Physicians, to develop model federal
3 legislation requiring health care facilities to inform patients in custody about their rights as a
4 patient under applicable federal and state law. (Directive to Take Action)

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

Received: 5/9/23

REFERENCES

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Referral Change
Was Resolution 504

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 256
(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 B

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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

REFERENCES

CLAUDIA E, HAUPT JSD. AI-GENERATED MEDICAL ADVICE—GPT AND BEYOND. PUBLISHED ONLINE MARCH 27, 2023. DOI:10.1001/JAMA.2023.5321

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-23)

Introduced by: Michigan

Subject: Prohibit Discriminatory ERAS® Filters In NRMP Match

Referred to: Reference Committee C

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1 Whereas, Graduate training programs require applicants to go through the Electronic Residency
2 Application Service® (ERAS®) for residency selection in the National Residency Match
3 Program (NRMP), and
4
5 Whereas, The ERAS® requires mandatory information be filled out in the application including,
6 but not limited to gender and medical school, and
7
8 Whereas, There are pre-programmed filters available in the ERAS® system such as being an
9 international medical graduate, and
10
11 Whereas, Many program directors apply these filters regularly, according to the survey by the
12 NRMP post-match data, and
13
14 Whereas, Many program directors admit to applying the medical school accreditation filter -
15 Liaison Committee on Medical Education (LCME) vs non-LCME - frequently in downloading
16 applications, and
17
18 Whereas, Applying this filter completely eliminates the downloading of all international medical
19 graduates' applications; thereby, preventing them from being considered regardless of how
20 competitive their applications may be, and
21
22 Whereas, AMA policy is not to discriminate candidates in residency selection based on their
23 education in foreign countries,
24
25 Whereas, According to Accreditation Council for Graduate Medical Education criteria, program
26 directors are required not to discriminate in the selection process of any group as a block;
27 therefore be it
28
29 RESOLVED, That our American Medical Association oppose the use of discriminatory filters for
30 foreign graduates in the Electronic Residency Application Service® (ERAS®) system and
31 aggressively work to eliminate discriminatory filters including, but not limited to, those based on
32 foreign medical school training, that prevent international medical graduates and others from
33 consideration based on merit. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

REFERENCES
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2. https://doi.org/10.4300/JGME-D-19-00345.1

RELEVANT AMA POLICY

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
Our AMA will: 1. encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
3. advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
4. advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
5. encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.
Citation: CME Rep. 02, 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;

AMA Principles on International Medical Graduates H-255.988
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.
Citation: 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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-23)

Introduced by: Illinois

Subject: Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges

Referred to: Reference Committee C

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1 Whereas, There is an increasing number of physicians experiencing burnout, a potential factor
2 in the increased rates of physicians having depression and committing suicide; and
3
4 Whereas, Physicians who have or have had mental health concerns may be reluctant to seek
5 treatment as it may cause difficulty in obtaining and/or renewing a medical license as well as
6 obtaining institutional privileges; and
7
8 Whereas, Physicians not receiving treatment for mental health issues may pose harm to
9 patients and can contribute to untreated burnout, depression as well as increased rates of
10 suicide; and
11
12 Whereas, Physicians have the right to obtain the same care as patients without retribution and
13 with respect of the privacy of physicians' protected health information; and
14
15 Whereas, The American Psychiatric Association has found no evidence that a physician who
16 has been treated for a mental illness is any more likely to harm a patient than a physician with
17 no mental health issues; and
18
19 Whereas, The Americans with Disabilities Act of 1990 states that employers can't discriminate
20 against employees based on mental or physical health; and
21
22 Whereas, The 2018 American Psychiatric Association Position Statement on Inquiries About
23 Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and
24 Licensing recommends that medical license bodies not inquire of applicants about prior
25 diagnosis and treatment of mental health disorders; and
26
27 Whereas, Per the 2018 American Psychiatric Association Position Statement on Inquiries About
28 Diagnosis and Treatment of Mental Disorders in Connection with Professional Credentialing and
29 Licensing: "Medical or hospital records requested shall be by way of narrowly tailored requests
30 and releases that provide access only to information that is reasonably needed to assess the
31 applicant's fitness to practice. All personal or health-related information shall be kept strictly
32 confidential and shall be accessed only by individuals with a legitimate need for such
33 access…Personal health information collected by the board should be kept confidential and
34 should be destroyed after a reasonable period of time"; and
35
36 Whereas, Many initial and renewal applications for medical licenses and associated applications
37 and application reference forms, medical specialty boards, and institutional privilege and
38 credential applications continue to include questions about physicians' mental health and

physicians who disclose a current or past mental health condition may be investigated or sanctioned; and

Whereas, Those applications that continue to make inquiries about a physician's mental health should use language consistent with Americans with Disabilities Act, which limit questions to whether the individual has a medical condition that *currently* impacts his or her ability to practice medicine; and

Whereas, In an analysis of state medical board applications and a survey of state medical board executives, 97% of the executives responded that the board was not required to sanction a physician who is diagnosed with a medical illness, yet 37% responded that a mental illness diagnosis alone was sufficient for sanctioning physicians; and

Whereas, AMA Policy H-275.970, *Licensure Confidentiality,* addresses issues of potential discrimination and confidentiality violations in the licensing, privileging and credentialing processes; therefore be it

RESOLVED, That our American Medical Association amend Policy H-275.970, *Licensure Confidentiality*, by addition to read as follows:

1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing and/or privileging, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards these entities to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to exclude from license application forms and associated application forms including credentialing/privileging application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards and related organizations; and (e) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.

2. Our AMA will encourage will verify that, by 2024, those state medical boards, specialty boards, hospitals, and other organizations involved in credentialing/privileging that wish to retain questions about the health of applicants on medical licensing applications use language consistent with that recommended by the Federation of State Medical Boards, which reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

3. Our AMA will work with the Federation of State Medical Boards, the American Hospital Association, the American Board of Medical Specialties, and state medical societies to develop policies and strategies to ensure that by 2024 all new and renewal medical licensure and associated applications and application reference forms, privileging, credentialing and related applications and documentation will request or disclose only information that is reasonably

1 needed to address the applicant's current fitness to practice medicine and respect the privacy of
2 physician's protected health information. (Modify Current HOD Policy)

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

Received: 5/5/23

REFERENCES

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2. Federation of State Medical Boards Physician Wellness and Burnout. Report and recommendations of the Workgroup on Physician Wellness and Burnout. Adopted as policy by the Federation of State Medical Boards April 2018. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf
3. Americans With Disabilities Act (ADA), 42 U.S.C. Sections 12101-12213. https://www.law.cornell.edu/uscode/text/42/12101

RELEVANT AMA POLICY

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945
The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.
Citation: (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)

Licensure Confidentiality H-275.970
1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.
2.Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).
Citation: CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-93; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: CME Rep. 06, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-23)

Introduced by: Illinois

Subject: Supporting Childcare for Medical Residents

Referred to: Reference Committee C

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1 Whereas, The healthcare field is experiencing a major shortage of physicians[1]; and
2
3 Whereas, Work-home conflicts, including decisions regarding family-life balance, have been
4 cited as a contributing factor to physician burnout[2]; and
5
6 Whereas, Over half of the surveyed residents report delaying childbearing, half of these cite
7 childcare as a contributing factor for this decision, and only 1/3 are content with this decision [3];
8 and
9
10 Whereas, Only 3% of resident respondents believe their institution provides adequate childcare
11 resources[4]; and
12
13 Whereas, Specific hospital centers have found providing childcare is more cost effective than
14 missed work days[5]; and
15
16 Whereas, Providing childcare will increase resident satisfaction and allow for more focused care
17 of patients[6]; and
18
19 Whereas, The American Medical Association has recognized the challenges facing residents as
20 parents in H-200.948 yet has not addressed specificities or ways to mitigate these challenges;
21 therefore be it
22
23 RESOLVED, That our American Medical Association reaffirm Policy D-200.974, *Supporting*
24 *Child Care for Health Care Professionals,* committing to investigate barriers to childcare for
25 medical trainees, as well as innovative childcare methods. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

The topic of this resolution is currently under study by the Council on Medical Education and will be presented as CME 1-I-23, *Leave Policies for Medical Students and Physicians*.

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RELEVANT AMA POLICY

Onsite and Subsidized Childcare for Medical Students, Residents and Fellows H-200.948
Our AMA recognizes: (1) the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules; and (2) the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows.
Citation: CME Rep. 3, A-22;

Supporting Child Care for Health Care Professionals D-200.974
Our AMA: (1) will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees); (2) encourages provision of onsite and/or subsidized childcare for medical students, residents, and fellows; and (3) will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and American Association of Colleges of Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative methods and best practices for instituting on-site and/or subsidized childcare that meets the unique needs of medical students, residents, and fellows.
Citation: Res. 309, A-21; Appended: CME Rep. 3, A-22;

Prescription Drug Diversion, Misuse and Addiction H-95.945
Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.
Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-23)

Introduced by: Illinois

Subject: Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions

Referred to: Reference Committee C

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1 Whereas, Recent research has found a strong association between higher hospital quality
2 rankings and the CEO being a physician. The majority of hospitals in the U.S. are led by non-
3 physicians. According to a study by the American College of Physician Executives in 2014, only
4 5% of hospitals were led by physicians; and
5
6 Whereas, Today's intricate healthcare system operates in a constantly changing environment,
7 requiring complex and demanding professional healthcare management. Being a physician
8 doesn't necessarily qualify one to be a super performing hospital CEO. In order to manage
9 hospitals in a competent manner, the need for physician CEOs who possess various managerial
10 skills as well as familiarity with problems in healthcare is strongly needed; and
11
12 Whereas, The idea of a medical doctor earning additional education or certification might seem
13 counterintuitive at first, given how much time physicians have already devoted to a bachelor's
14 degree, medical school and a residency before they begin to practice. However, the benefits of
15 education in healthcare leadership can merit the extra investment in time, money and effort;
16 therefore be it
17
18 RESOLVED, That our American Medical Association encourage education for medical trainees
19 in healthcare leadership, which may include additional degrees at the master's level and/or
20 certificate programs, in order to increase physician-led healthcare systems. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will

advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
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.
Citation: Sub. Res. 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;

Health Care Economics Education D-295.321
Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician’s professional life, including undergraduate medical education, graduate medical education and continuing medical education.
Citation: Res. 320, A-09; Reaffirmation I-15; Modified: CEJA Rep. 01, A-20;

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.
Citation: CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Reaffirmation A-12; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17; Modified: CME Rep. 2, I-19;

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.
Citation: Sub. Res. 301, A-13; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement

Referred to: Reference Committee C

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1 Whereas, Diversity, Equity, and Inclusion (DEI) programs are formal offices, resources, and
2 structures that promote expansion of community representation at an institution, advocate for
3 equal access to opportunities, and increase overall sense of belonging and respect among
4 individuals;[1-3] and
5
6 Whereas, The majority of medical schools host diversity initiatives including, but not limited to,
7 community outreach, pathway programs for underrepresented in medicine (URM) individuals,
8 and free clinics;[4] and
9
10 Whereas, Academic medical centers rely on medical students, often historically URM
11 individuals, to promote diversity initiatives;[5-6] and
12
13 Whereas, “Minority tax” includes the cumulative effects of additional responsibilities placed on
14 minority faculty and trainees to promote DEI initiatives, which can detract from other academic
15 endeavors and emotional well-being and lead to burnout and exits from the DEI space;[7-16] and
16
17 Whereas, DEI work at academic medical institutions is hindered by limited financial support,
18 limited dedicated staff, directives skewed toward broad generalities, and under-appreciation and
19 under-compensation of the trainees, community members, and scholars engaged in these
20 missions;[17] and
21
22 Whereas, Faculty and staff may be discouraged from participating in DEI initiatives considering
23 only 35.6% of medical schools offer incentives for employees to meet DEI goals and 43.6%
24 have career advancement policies as a reward for DEI work;[18] and
25
26 Whereas, Ongoing state efforts attacking DEI initiatives and opposing their funding, to limit
27 consideration of DEI criteria in employment decisions, and opposing affirmative action for
28 students and trainees threaten to hinder the initiatives that promote diversity in the physician
29 workforce and encourage a multicultural education that better allows physicians to understand
30 unique patient needs;[19-25] and
31
32 Whereas, Physician representation better aligned with the US population is associated with
33 improved health measures;[26] and
34
35 Whereas, The Supreme Court of the United States (SCOTUS) anticipated ruling on affirmative
36 action cases brought forth my Students for Fair Admissions (SFFA) in 2023 poses a significant
37 threat to the promotion of DEI at higher education institutions;[27] and

Whereas, The Association of American Medical Colleges' (AAMC's) "The Power of Collective Action: Assessing and Advancing Diversity, Equity, and Inclusion Efforts at AAMC Medical Schools" found that institutional accountability for advancing DEI resources to support DEI was critical to ensuring institutional DEI advances;[4] therefore be it

RESOLVED, That our American Medical Association recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure (Directive to Take Action); and be it further

RESOLVED, That our AMA amend D-295.963, *Continued Support for Diversity in Medical Education,* by addition and deletion to read as follows:

> Our AMA will: (1) publicly state and reaffirm its ~~stance on~~ support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-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.
BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA
(1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities;
(2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and
(3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes

the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, 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.
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

Service Learning in Medical Education H-295.880
Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.
Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

Referred to: Reference Committee C

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1 Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access
2 to jobs and professions such as medicine and based on the premise that relief from illegal racial
3 discrimination is not enough to remove the burden of overt and covert prejudice limiting social,
4 educational, and fiscal mobility for minoritized groups[1,2]; and
5
6 Whereas, Affirmative action has been identified as a potent method for ameliorating racial
7 disparities and increasing diversity in public universities;[3,4] and Whereas, University enrollment
8 is directly correlated with attaining higher social status through increased access to professions
9 such as medical practice[5]; and
10
11 Whereas, Racial diversity in the medical field fosters a greater understanding of patient
12 populations through racial concordance; as it has been shown through peer reviewed literature
13 that health outcomes for patients belonging to minoritized groups are improved when there is
14 shared racial identity between patient and provider[6,7,8,9]; and
15
16 Whereas, Physicians belonging to minoritized groups are more likely to practice in areas with
17 limited access to medical resources, and more often serve populations with higher percentages
18 of patients who are disproportionately impacted by racial health disparities[10,11,12,13]; and
19
20 Whereas, Several states that have instituted bans on affirmative action have experienced
21 subsequent decreases in college enrollment by minority students, completion of STEM degrees
22 by minority students, and representation of minority students among matriculating medical
23 school students[14,15]; and
24
25 Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of
26 *Regents of the University of California v. Bakke*, *Grutter v. Bollinger*, and *Fisher v. The*
27 *University of Texas at Austin,* respectively, allowing race to be one of several factors in college
28 admission policy[16,17,18,19]; and
29
30 Whereas, Although AMA policy establishes a significant precedent to support undergraduate
31 education as a means to produce medical school matriculants (H-60.917, H-350.979, H-
32 200.985), existing policy falls short of addressing the necessity of affirmative action as
33 mechanism for equality at the undergraduate level, which is necessary to bolster the pool of
34 students belonging to racially minoritized groups who are eligible to apply to medical programs;
35 and
36
37 Whereas, Race-Conscious Admissions directly empowers institutions of higher education to
38 optimize the learning environment by fostering diverse representations of race, culture,
39 nationality, and experience to best serve the advancement of knowledge creation and service to

humankind, particularly in light of centuries-long efforts to eliminate opportunities for non-White individuals to read or white through Anti-Literacy Laws,[20] and to eradicate representation of non-White individuals in spaces of higher education through racial segregation of schools and universities[21]; and

Whereas, Two lawsuits challenging the application of race as a measure of affirmative action for admissions decisions at Harvard and The University of North Carolina is currently under the consideration of the Supreme Court [22, 23] and serve two functions: 1) seeking to name race-conscious admissions as a form of racial discrimination and in violation of the Equal Protection Clause, and 2) threatening the application of affirmative action measures towards the expansion of racial diversity in medical schools and higher education nationwide; therefore be it

RESOLVED, That our American Medical Association amend H-350.979, *Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession,* by deletion and addition to read as follows:

> (3) urging medical school and undergraduate admissions committees to c~~onsider minority representation as one factor in reaching their decisions~~ proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend D-200.985, *Strategies for Enhancing Diversity in the Physician Workforce*, by deletion and addition to read as follows:

> (12) unequivocally opposes legislation that would ~~undermine institutions' ability to properly employ~~ dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA recognize the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that 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) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

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.

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work

with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-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.
BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA
(1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities;
(2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and
(3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, 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.
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

Service Learning in Medical Education H-295.880
Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.
Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-23)

Introduced by: New York

Subject: Corporate Compliance Consolidation

Referred to: Reference Committee C

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1 Whereas, Physicians have ever increasing non-clinical educational requirements that occupy
2 time otherwise needed for direct patient care; and
3
4 Whereas, Most hospitals and practices are requiring physicians to take multiple educational
5 courses in corporate compliance with topics such as the Health Insurance Portability and
6 Accountability Act (HIPPA), fraud and abuse prevention, sexual harassment, diversity and
7 inclusiveness, the Occupational Safety and Health Administration (OSHA), and emergency
8 preparedness on a yearly basis; and
9
10 Whereas, The vast majority of these courses have similar or identical content which is
11 determined by The Centers for Medicare & Medicaid Services (CMS), the New York State
12 Department of Health (NYS DOH), and other government agencies; and
13
14 Whereas, Many independent physicians have privileges in multiple settings which may require
15 yearly completion of courses for each of these settings which results in redundancy of
16 essentially identical educational requirements and wastes valuable physician time and effort;
17 therefore be it
18
19 RESOLVED, That our American Medical Association work to create a minimum, standard
20 curriculum for corporate compliance education requirements, the completion of which is
21 acceptable to all stakeholders (Directive to Take Action); and be it further
22
23 RESOLVED, That our AMA advocate for satisfactory completion of the new approved standard
24 corporate compliance curriculum at one setting to fulfill the requirements of all settings that
25 require such a mandate, to eliminate wasting of valuable physician time and effort. (Directive to
26 Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 322
(A-23)

Introduced by: New York

Subject: Disclosure of Compliance issues and Creating a National Database of Joint Leadership

Referred to: Reference Committee C

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1 Whereas, Accreditation Council for Continuing Medical Education (ACCME) is the national
2 organization which sets all policy and procedures for all accredited Continuing Medical
3 Education (CME); and
4
5 Whereas, ACCME serves as an accreditor as well as the authority for recognition of state
6 medical societies which serve both as recognized accreditors and providers of accredited CME;
7 and
8
9 Whereas, ACCME has developed the new standards for integrity and independence in
10 Accredited Continuing Education which were adopted on Jan 1, 2022, as necessary for
11 compliance in accredited CME; and
12
13 Whereas, ACCME collects data and maintains registries such as the Program and Activity
14 Reporting System (PARS) which is a source of information for accredited providers; and
15
16 Whereas, MSSNY and other State Medical Societies (SMS) have limited resources and staff to
17 ensure that non-accredited provider applicants are not submitting applications which have been
18 previously denied accreditation due to compliance issues with the new standards; and
19
20 Whereas, There is no mechanism currently in place for accredited providers to have access for
21 a timely review of the previously denied accreditation due to compliance issues with the new
22 standards; and
23
24 Whereas, The American Medical Association is a founding member of ACCME with
25 representation on the board of ACCME; therefore be it
26
27 RESOLVED, That our American Medical Association urge the Accreditation Council for
28 Continuing Medical Education to require organizations that apply for joint providership for
29 accreditation of Continuing Medical Education activities to disclose on its application if the
30 activity has previously been denied accreditation and the reason for denial (Directive to Take
31 Action); and be it further
32
33 RESOLVED, That our AMA urge the Accreditation Council for Continuing Medical Education to
34 develop a national database for this information (in a manner similar to the Program and Activity
35 Reporting System) which would allow State Medical Societies providers to cross-reference this
36 information. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

RELEVANT AMA POLICY

Restoring Integrity to Continuing Medical Education H-300.988
The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit.
Citation: CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-23)

Introduced by: Minnesota

Subject: Examining Policing Through a Public Health Lens

Referred to: Reference Committee D

Whereas, Police brutality and negative police interactions many times are products of structural racism; and

Whereas, Black, Indigenous, and Hispanic/Latino individuals are significantly more likely to be killed or injured by police than White individuals; and

Whereas, Being killed by police is the sixth leading cause of death for young Black men; and

Whereas, Both Black women and Indigenous women are about 1.5 times more likely to be killed by police than White women; and

Whereas, Police surveillance, police stops, and verbal harassment can have large and disproportionate public health impacts, even absent physical violence by police; and

Whereas, Policing has shown to have a detrimental effect on the mental, physical and economic health of Black, Indigenous, Hispanic/Latino and other communities of color; and

Whereas, Systems need to be put in place to address the adverse health outcomes that are occurring as a result of policing policies that are influenced by structural racism; and

Whereas, Given the recent public and media interest of deaths in custody, these deaths have the potential to be publicly scrutinized not just for how the situation was handled by law enforcement, but also for how the case was managed by the medical examiner, forensic pathologist, or coroner; and

Whereas, “Death in custody" refer to those deaths in which the death happens while the decedent is in either direct or indirect contact with law enforcement, whether during an initial confrontation with law enforcement authorities, during the process of arrest, during transport to a facility, or during incarceration; and

Whereas, Deaths in custody are complex issues that require medical examiners, forensic pathologists, or coroners to be knowledgeable and deliberative about their diagnoses; and

Whereas, It is critical that medical examiners, forensic pathologists, or coroners manage investigations/evaluations of deaths in custody using a consistent and uniform approach; and

Whereas, The U.S. Standard Certificate of Death does not have a standard way of capturing a death in custody; and

1 Whereas, It is up to the discretion of the medical examiner, forensic pathologist, or coroner to
2 communicate the circumstances of deaths in custody by using the “How Injury Occurred” and
3 “Place of Death” sections contained within the death certificate, a practice that may miss many
4 deaths if they are not correctly noted; and
5
6 Whereas, To assist in the accurate accounting of deaths in custody, an appropriate mechanism
7 needs to be added to the U.S. Standard Certificate of Death to record deaths in custody;
8 therefore be it
9
10 RESOLVED, That our American Medical Association advocate for research to be conducted
11 that examines the public health consequences of negative police interactions (Directive to Take
12 Action); and be it further
13
14 RESOLVED, That our AMA advocate for a change to the U.S. Standard Certificate of Death to
15 include a “check box” that would categorize deaths in custody and would create a new statistical
16 grouping with explanations of the range of causes, manner and circumstances of death, within
17 the spectrum of police custody, corrections custody, and legal custody. (Directive to Take
18 Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/3/23

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RELEVANT AMA POLICY

Policing Reform D-65.987
Our AMA: (1) will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement; (2) will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death; (3) encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities; and (4) supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.
Citation: BOT Rep. 2, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-23)

Introduced by: Dr. Thomas W. Eppes, MD, Delegate

Subject: Accurate Abortion Reporting with Demographics by the Center for Disease Control

Referred to: Reference Committee D

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1 Whereas, The Center for Disease Control (CDC) is the government's premier analytics body for
2 healthcare trends and data collection; and
3
4 Whereas, The CDC has been collecting voluntary data on abortions since Roe v Wade; and
5
6 Whereas, That current data does not contain data points that allow full understanding of the
7 consistent demographics that would allow full understanding of numbers, complications, and
8 demographics that would allow wise policy decisions; therefore be it
9
10 RESOLVED, That our American Medical Association call upon the Center for Disease Control
11 (CDC) to develop and mandate collection of abortion statistics from each state that at minimum
12 include the following data:
13 1) Age of the woman.
14 2) Race of the woman.
15 3) Facility [Hospital, Ambulatory Surgery Center, Private Center meeting ASC
16 standards, Private Center not meeting ASC standards.
17 4) Gestational age of pregnancy.
18 5) The abortion procedure or medication chosen.
19 6) Reason for abortion [life of the mother, rape, incest, choice].
20 7) Miles traveled to obtain the abortion and whether the woman had to go out of state
21 due to state laws prohibiting abortion care.

(Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-23)

Introduced by: Delaware

Subject: Minimizing the Influence of Social Media on Gun Violence

Referred to: Reference Committee D

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1 Whereas, More Americans died of gun-related injuries in 2021 (the most recent year for which
2 complete data is available) than in any other year on record totaling 48,830, which includes gun
3 murders, gun suicides, accidental death, deaths involving law enforcement, and those whose
4 circumstances could not be determined[1]; and
5
6 Whereas, Suicides have long accounted for the majority of US gun deaths, with 54% of all gun-
7 related deaths in the US in 2021 being suicides (26,328)[1]; and
8
9 Whereas, 43% of all gun-related deaths in the US in 2021 were murders (20,958)[1]; and
10
11 Whereas, Approximately eight-in-ten US murders in 2021 (81%) involved a firearm, marking the
12 highest percentage since at least 1968[1]; and
13
14 Whereas, Since the beginning of the pandemic, there was a significant increase in gun deaths
15 among children and teens under the age of 18[1]; and
16
17 Whereas, A number of social media sites such as Facebook, Instagram, Yubo, Twitter, Tumblr,
18 YouTube, Pinterest, Flickr, TikTok, and Reddit are popular sites for many young people and
19 others to communicate and share ideas[2]; and
20
21 Whereas, Studies have suggested that social media has contributed to the rise and proliferation
22 of gun violence by encouraging imitative behaviors, provoking retaliative actions, and offering
23 “bragging rights” in some online communities[3]; and
24
25 Whereas, Mental health illness may instill a sense of low self-worth that may lead to suicidal
26 tendencies that can be fueled by social media postings; and
27
28 Whereas, As social networks refine their policies and update algorithms for detecting
29 extremism, they overlook a major source of the proliferation of hateful content relating to the use
30 of gun violence[4,5]; and
31
32 Whereas, Social media sites have an obligation to perform ongoing surveillance of their sites to
33 detect inappropriate and unlawful postings, videos, messaging, and more[4-7]; and
34
35 Whereas, Social media sites have not been aggressive enough in controlling postings on their
36 site and taking down such postings that glorify guns and gun violence, as well as removing
37 users that post such information indefinitely[4-10]; and
38
39 Whereas, Fear of retribution may be a significant reason why social media sites cannot control
40 their content on guns and gun violence adequately; and

1 Whereas, Criticism from gun lobbies, politicians, and Second Amendment advocates hamper
2 control of guns and gun violence on social media[4]; and
3
4 Whereas, Social media can be used to provide useful content to combat gun violence [9,11-13];
5 therefore be it
6
7 RESOLVED, That our American Medical Association call upon all social media sites and all
8 others that allow posting of videos, photographs, and written online comments encouraging and
9 glorifying the use of guns and gun violence to vigorously and aggressively remove such
10 postings (Directive to Take Action); and be it further
11
12 RESOLVED, That our AMA strongly recommend social media sites continuously update and
13 monitor their algorithms in order to detect and eliminate any information that discusses and
14 displays guns and gun violence in a way that encourages viewers to act violently (New HOD
15 Policy); and be it further
16
17 RESOLVED, That our AMA work with social media sites to provide educational content on the
18 use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating
19 effects of gun violence in our communities. (Directive to Take Action)

Fiscal Note: Developing educational content - $50,070.

Received: 5/9/23

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RELEVANT AMA POLICY

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

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;

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.
Citation: Res. 905, I-17; Modified: Res. 420, A-21;

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: 428
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Mattress Safety in the Hospital Setting

Referred to: Reference Committee D

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1 Whereas, It is the responsibility of the organized medical staff to oversee the safety of patients
2 in the hospital setting; and
3
4 Whereas, Covering hospital safety includes working to mitigate and overall decrease infections;
5 and
6
7 Whereas, Materials in the patients' room such as the hospital bed and matters can be a
8 causative agent of infection spread; and
9
10 Whereas, Proper care of the hospital bed and mattress comes under the purview of the
11 organized medical staff as well as accrediting bodies; and
12
13 Whereas, The U.S. Food and Drug Administration and hospital bed/mattress manufacturers
14 have specific instructions on the care and maintenance of hospital beds and mattresses;
15 therefore be it
16
17 RESOLVED, That our American Medical Association work with the accrediting bodies and
18 interested stakeholders to make sure all possible appropriate care and maintenance measures
19 be undertaken to mitigate infection related to hospital bed and mattress use (Directive to Take
20 Action).

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

Received: 5/9/23

RELEVANT AMA POLICY

Responsibility for Infection Control (H-235.969)
AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.
Citation: Sub. Res. 802, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

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; Reaffirmed: A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-23)

Introduced by: American Association of Public Health Physicians

Subject: Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System

Referred to: Reference Committee D

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1 Whereas, The US has the highest incarceration rate in the world; and
2
3 Whereas, Evidence indicates that Black Americans are incarcerated in local jails and prisons at
4 four times the rate of white Americans; and
5
6 Whereas, The Supreme Court held all prisoners have the right to adequate medical care while
7 incarcerated; and
8
9 Whereas, The standard of health care treatment within correctional facilities is the same as in
10 the community at large; and
11
12 Whereas, Studies have shown that compared to the general population, individuals in jail and
13 prisons have are more likely to have high blood pressure, asthma, cancer, arthritis, and
14 infectious diseases such as tuberculosis, hepatitis C, and HIV; and
15
16 Whereas, Individuals who are incarcerated are vulnerable to the spread of COVID-19 infection
17 due to their close confined quarters; and
18
19 Whereas, Individuals who are incarcerated have a high chronic disease burden, increasing their
20 risk for morbidity and mortality related to COVID-19; and
21
22 Whereas, According to the UCLA Law COVID-19 Behind Bars Project, more than 412,000
23 people incarcerated in prisons have had confirmed cases of COVID-19 and over 2,700 people
24 have died from COVID-19 while incarcerated; and
25
26 Whereas, The case and death rates in US prisons substantially exceeded national rates; and
27
28 Whereas, As of April 2, 2021, 394,066 COVID-19 cases and 2,555 deaths due to COVID-19
29 had been reported among the US prison population, with a standardized mortality rate of 199.6
30 deaths for the prison population and 80.9 deaths for the US population; and
31
32 Whereas, There were 296 federal inmate deaths attributed to COVID-19 infections; and
33
34 Whereas, The reported number of deaths may be underestimated secondary to delay in
35 reporting and due to inadequate availability of testing at the start of the COVID-19 pandemic;
36 and
37
38 Whereas, The current qualifications for national and local administrators within Bureau of
39 Prisons do not include medical credentials or clinical experience; and

1 Whereas, Administrators without clinical experience in medicine, nursing, public health, or
2 health service administration are regularly promoted to positions where they supervise
3 physicians and other clinical staff; and
4
5 Whereas, Administrators direct the process and procedures of routine and acute clinical care as
6 well as managing public health crises such as the COVID-19 pandemic; and
7
8 Whereas, Individuals who are confined to correctional facilities do not have a right to request
9 health care outside of the correctional facilities; therefore be it
10
11 RESOLVED, That our American Medical Association support the following qualifications for the
12 Director and Assistant Director of the Federal Bureau of Prisons positions and other
13 administrators supervising physicians and other clinical staff within its facilities:
14
15 1. MD or DO, MBSS, degree with at least five years of clinical experience at a Bureau of
16 Prisons medical facility or a community clinical setting.
17 2. Knowledge of health disparities among Black, Indigenous, and people of color, including the
18 pathophysiological basis of the disease process and the social determinants of health that
19 affect disparities.
20 3. Knowledge of the health disparities among individuals who are involved with the criminal
21 justice system (New HOD Policy); and be it further
22
23 RESOLVED, That our AMA initiate a public health campaign or appropriate effort to promote the
24 highest quality of healthcare and oversight for those who are involved in the criminal justice
25 system by advocating for health administrators and executive staff to possess credentials and
26 experience comparable to individuals in the community in similar professional roles. (Directive to
27 Take Action)

Fiscal Note: Initiating a public health campaign - $43,166.

Received: 5/10/23

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3. https://www.themarshallproject.org/2021/07/01/prisons-have-a-health-care-issue-and-it-starts-at-the-top-critics-say
4. https://www.npr.org/2022/03/07/1085020336/covid-19-inmate-deaths-in-prisons
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-23)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Teens and Social Media

Referred to: Reference Committee D

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1 Whereas, American Medical Association policy H-60.934, *Internet Pornography: Protecting*
2 *Children and Youth Who Use the Internet and Social Media,* addresses "Protecting Children and
3 Youth Who Use the Internet and Social Media"; and
4
5 Whereas, According to one report, "nearly 3 in 5 US teen girls felt persistently sad or hopeless
6 in 2021 – the highest level reported over the past decade"[1]; and
7
8 Whereas, In a recent health advisory, the American Psychological Association (APA)
9 recommends that "3. in early adolescence (i.e., typically 10-14 years), adult monitoring is
10 advised for most youths' social media use…"[2]; and
11
12 Whereas, APA also recommends that "4.To reduce the risks of psychological harm,
13 adolescents' exposure to content on social media that depicts illegal or psychologically
14 maladaptive behavior, including content that instructs or encourages youth to engage in health-
15 risk behaviors, such as self-harm (e.g., cutting, suicide), harm to others, or those that encourage
16 eating-disordered behavior (e.g., restrictive eating, purging, excessive exercise) should be
17 minimized, reported, and removed; moreover, technology should not drive users to this content.
18 …" [2]; and
19
20 Whereas, APA also recommends that "5. To minimize psychological harm, adolescents'
21 exposure to "cyberhate" including online discrimination, prejudice, hate, or cyberbullying
22 especially directed toward a marginalized group (e.g., racial, ethnic, gender, sexual, religious,
23 ability status), 22 or toward an individual because of their identity or allyship with a marginalized
24 group should be minimized"[2]; and
25
26 Whereas, APA also recommends that "6. Adolescents should be routinely screened for signs of
27 "problematic social media use" that can impair their ability to engage in daily roles and routines,
28 and may present risk for more serious psychological harms over time"[2]; and
29
30 Whereas, The state of Utah recently passed social media regulations that (1) require age
31 verification prior to opening a social media account, (2) require parental consent before minors
32 in Utah may maintain or open a social media account, (3) require social media accounts for
33 minors in Utah to: (a) not display advertising, (b) not collect, share, or use personal information
34 from that account, (c) not target or suggest ads, accounts, or content, and (d) limit hours of
35 access; and
36
37 Whereas, There are age limits for driver's licenses, tobacco use, alcohol use, and renting
38 vehicles in the United States; therefore be it

1 RESOLVED, That our American Medical Association study and make recommendations for age
2 limits on teenage use of social media, including proposing model state and federal legislation as
3 needed, with a report back at the 2024 Annual Meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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2. "Health advisory on social media use in adolescence at apa.org, <https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use>, accessed 5/10/23
3. "Social Media Regulation Amendments" in Utah S.B.152, at <https://le.utah.gov/~2023/bills/static/SB0152.html>, and "Social Media Usage Amendments" in Utah H.B. 311 at <https://le.utah.gov/~2023/bills/static/HB0311.html>.

RELEVANT AMA POLICY

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Our AMA:
(1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
(6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.
Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-23)

Introduced by: Minority Affairs Section, National Medical Association

Subject: Qualified Immunity Reform

Referred to: Reference Committee D

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1 Whereas, Historically marginalized and minoritized groups in the United States including people
2 with psychiatric or substance use disorders, people who are undomiciled, people who identify as
3 LGBTQ+, people with lower socioeconomic status, and people from racial and ethnic minority
4 groups (DeVylder et al 2022), shoulder the unfair, unjust, and disproportionate burden of police
5 violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational
6 trauma, such that. police violence is a leading cause of death for young men in the United
7 States, and 1 in 1000 Black men die as a result of police violence[1]; and
8
9 Whereas, Black Americans are three times more likely than white Americans to be killed by
10 police and account for over 40% of victims of police killings nationwide[5]; and
11
12 Whereas, Police violence and incarceration cause significant long-term far reaching negative
13 effects on the mental, physical and economic health of impacted individuals, their loved ones,
14 and their communities[6-19]; and
15
16 Whereas, In a national survey of police officers, while about 75% believed it is unacceptable to
17 use more force than necessary, about 25% believed that it is ok to use more force than
18 necessary to control someone who assaulted an officer and; 84% stated that officers in their
19 department used more force than necessary at times when making an arrest; over 62%
20 reported that officers in their department responded to verbal abuse with physical force; over
21 67% reported that officers in their department faced negative consequences if they reported
22 misconduct[20]; and
23
24 Whereas, In that same survey of police officers, 49% reported that someone is more likely to be
25 arrested if the officer believes they displayed a “bad attitude;” 47% reported that officers treat
26 white people better than Black people; over 11% believe that officers are more likely to use
27 physical force against Black or other minority people in similar situations; 14% believe that
28 officers are more likely to use force against poor people than middle class people in similar
29 situations; <12% of white officers believed that officers were more likely to use force against
30 Black or other minority people but over 53% of Black officers believe officers were more likely to
31 use force against Black or other minority people[20]; and
32
33 Whereas, Excessive use of force is harmful to law enforcement officers because law
34 enforcement officers themselves experience high rates of traumatic stress, depression, anxiety
35 and moral injury when they participate in or witness violence against the citizens they are sworn
36 to protect[21-23]; and
37
38 Whereas, The criminal justice system has not proven to be an effective avenue for justice for
39 people wrongfully injured or their survivors when someone is wrongfully killed by police, such
40 that 12.9% of white people and 16.8% of Black people killed by police are unarmed, yet only 4%

of law enforcement officers who have killed someone are charged with a crime and only 25% of those charged (or 1% overall) are convicted[2, 24]; and

Whereas, Qualified immunity is a federal legal doctrine in the United States that protects law enforcement officers from civil litigation, including in cases in which they use excessive force, intended to protect officers who make mistakes in high-stress, high-paced situation[22, 27]; and

Whereas, In 2009, the Supreme Court ruling Pearson v. Callahan allowed judges to ignore the question of whether excessive force was used and decide only whether the officer's conduct was "clearly established as unlawful" and violated "clearly established" rights, a requirement that is hardly ever met in lower courts due to the need for the plaintiff to identify a previously decided case involving the exact same "specific context" and "particular conduct"[28-29]; and

Whereas, Lawyers are highly disincentivized from taking on a case against law enforcement's use of excessive force, since plaintiffs in cases dismissed on the basis of qualified immunity cannot recover fees or be appropriately compensated[28-29]; and

Whereas, Despite good intentions, qualified immunity protects the majority of law enforcement officers from ever going to trial even in cases of egregious excessive force and makes it increasingly difficult for citizens to win these cases, to the extent that 12.9% of white people and 16.8% of Black people killed by police are unarmed, but only 4% of law enforcement officers who kill people are ever charged of a crime and only 1% are ever convicted[28]; and

Whereas, Cases that have been dropped due to qualified immunity include a mistaken identity in which the victim was shot 17 times; an unarmed victim being smashed into a car for having a cracked windshield; and a 14-year-old boy being shot after dropping a pellet gun and raising his hands in the air, among many others[28]; and

Whereas, While some argue qualified immunity is necessary to protect officers from the burden of litigation, personal financial responsibilities, and potential bankruptcy, a study of more than 80 state and local law enforcement agencies across the country found that in instances of misconduct, the municipality or union, rather than individual officers, almost always paid, and another study of over 1,000 lawsuits against law enforcement officers found qualified immunity is rarely applied early enough in proceedings to protect officers from civil discovery (only 0.6 percent of the cases)[29-31]; and

Whereas, Qualified immunity has thus created a justice system that perpetuates violence as law enforcement officers who commit brutality and harassment—and the governments that employ them—have little incentive to improve their practices and follow the law given the lack of consequences; and

Whereas, Since June 2020 both Colorado and Connecticut have passed legislation to eliminate qualified immunity and federal legislation has been introduced into congress; therefore be it

RESOLVED, That our American Medical Association recognize the way we police our communities is a social determinant of health (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

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.

Policing Reform D-65.987
Our AMA: (1) will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement; (2) will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death; (3) encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities; and (4) supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.

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.

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.

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

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.

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.

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.

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.

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.

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.

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.

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.

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-23)

Introduced by: New Jersey

Subject: Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States

Referred to: Reference Committee E

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1 Whereas, South Asians, individuals with origins in Bangladesh, Bhutan, India, the Maldives,
2 Nepal, Pakistan, and Sri Lanka, comprise nearly 5.4 million people and are a rapidly growing
3 ethnic minority group in the United States; and
4
5 Whereas, South Asians have a higher risk of cardiovascular disease compared to other ethnic
6 groups, including higher rates of coronary artery disease, stroke, and type 2 diabetes; and
7
8 Whereas, The risk factors for cardiovascular disease in South Asians are different from those in
9 other ethnic groups, including higher rates of insulin resistance, low levels of high-density
10 lipoprotein (HDL) cholesterol, and a genetic predisposition to heart disease; and
11
12 Whereas, South Asians face unique cultural and linguistic barriers to accessing healthcare
13 services, including lack of knowledge about preventive care, language barriers, and cultural
14 beliefs that may affect health-seeking behaviors; and
15
16 Whereas, There is a paucity of data on the populations' unique cardiovascular disease risk
17 profiles, etiologic mechanisms, and effective interventions to address the health disparities
18 affecting South Asians in the United States; therefore be it
19
20 RESOLVED, That our American Medical Association support and advocate for additional NIH
21 funding to study disparities in population health due to genetic predispositions, which lead to
22 diseases with high morbidity such as cardiovascular disease in South Asian patients (Directive
23 to Take Action); and be if further
24
25 RESOLVED, That our AMA encourage the development of collaborative partnerships with other
26 organizations, institutions, policymakers, and stakeholders to reduce health disparities arising
27 from genetic predispositions and any accompanying cultural and linguistic barriers, through the
28 creation of educational campaigns and outreach programs. (New HOD Policy)

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

Received: 5/4/23

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2. Jayapal Celebrates House Passage of Landmark South Asian Heart Health Legislation https://jayapal.house.gov/2022/07/27/jayapal-celebrates-house-passage-of-landmark-south-asian-heart-health-legislation/
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 518
(A-23)

Introduced by: American Thoracic Society

Subject: Defending NIH funding of Animal Model Research From Legal Challenges

Referred to: Reference Committee E

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1 Whereas, Our American Medical Association has long supported the ethical use of animals in
2 research to study human diseases; and
3
4 Whereas, Our AMA has clearly established policy in support of ethical animal model research;
5 and
6
7 Whereas, Animal rights organizations oppose animal model research in all its forms; and
8
9 Whereas, People for the Ethical Treatment of Animals (PETA) has filed a suit (PETA v Tabak) in
10 federal court challenging National Institutes of Health's (NIH's) decision to fund 5 grants
11 studying sepsis in rodents; and
12
13 Whereas, Sepsis is a serious health condition that results in an estimated 1.7 million cases in
14 the US and approximately 350,000 US deaths annually; and
15
16 Whereas, Further research is needed to understand how to prevent sepsis infections and to
17 develop more effective interventions to treat sepsis infections; and
18
19 Whereas, If the court rules in favor of the plaintiffs it may establish a precedent that will invite
20 further legal challenges to federal support for animal model research; therefore be it
21
22 RESOLVED, That our American Medical Association join other medical professional societies in
23 an amicus brief supporting that National Institutes of Health's decision to fund grants to study
24 sepsis in rodent animal models (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA reaffirm its support of the use of animal model research that abides
27 by National Institutes of Health's ethical guides on the use of animals in research. (New HOD
28 Policy)

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

Received: 5/10/23

RELEVANT AMA POLICY

Medical Research Involving Animals H-460.957
The AMA urges state and county medical societies to support the appropriate and humane use of animals in research and to help ensure the continued availability of animals for essential medical education and medical research; and reaffirms its support for the appropriate and compassionate use of animals in biomedical research programs.
Citation: Sub. Res. 94, I-90; Sub. Res. 511, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

Use of Animals in Research H-460.979
(1) Researchers should include in their protocols a commitment to ethical principles that promote high standards of care and humane treatment of all animals used in research. Further, they should provide animal review committees with sufficient information so that effective review can occur. For their part, institutions should strengthen their animal review committees to provide effective review of all research protocols involving animals. (2) The appropriate and humane use of animals in biomedical research should not be unduly restricted. Local and national efforts to inform the public about the importance of the use of animals in research should be supported. (3) The development of suitable alternatives to the use of animals in research should be encouraged among investigators and supported by government and private organizations. The selection of alternatives ultimately must reside with the research investigator.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 7, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 519
(A-23)

Introduced by: GLMA: Health Professionals Advancing LGBTQ+ Equality

Subject: Rescheduling or Descheduling Testosterone

Referred to: Reference Committee E

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1 Whereas, An estimated 2.3 million Americans received testosterone therapy in 2013, with one-
2 half of all prescriptions written by primary care clinicians[1]; and
3
4 Whereas, Testosterone therapy treats conditions for cisgender men, cisgender women, and can
5 help bring a transgender or gender diverse (TGD) person's physical characteristics in line with
6 their gender identity, significantly reducing negative psychological outcomes such as
7 depression, anxiety and suicidality[2]; and
8
9 Whereas, A significant proportion of all testosterone prescriptions are written for TGD people
10 with an estimated 78% of the estimated 480,000 transgender men and non-binary adults in the
11 US seeking hormone therapy[3]; and
12
13 Whereas, The United States is the only developed country that treats testosterone as a
14 controlled substance[4]; and
15
16 Whereas, In 1990 the US Drug Enforcement Administration (DEA) classified testosterone and
17 other anabolic androgenic steroids (AAS) as Schedule III substances, which have a potential for
18 low or moderate physical dependence or high psychological dependence when misused[5]; and
19
20 Whereas, The DEA classification creates barriers to testosterone therapy and subjects patients
21 to criminalization, discrimination, and harassment[6]; and
22
23 Whereas, The DEA classification potentially limits the utilization of telemedicine for provision of
24 testosterone therapy[7]; and
25
26 Whereas, Rescheduling or descheduling testosterone has the potential to eliminate numerous
27 barriers to access for patients, especially TGD persons[6]; therefore be it
28
29 RESOLVED, That our American Medical Association urge the United States Drug Enforcement
30 Administration to reschedule or deschedule testosterone as a Schedule III substance. (New
31 HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of
continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating
factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 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

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122 A-08 Modified: Res. 05, A-16 Reaffirmed: Res. 012, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-23)

Introduced by: Illinois

Subject: Supporting Access to At-Home Injectable Contraceptives

Referred to: Reference Committee E

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1 Whereas, Nearly half of all pregnancies in the United States are unplanned; and
2
3 Whereas, Costs of unplanned pregnancy within the healthcare system reach over 4.5 billion
4 dollars annually; and
5
6 Whereas, Improper contraceptive adherence is cited as the cause of over half of these
7 unplanned pregnancies; and
8
9 Whereas, Increased access to reliable methods of contraception would target this failure and
10 therefore decrease the number of unplanned pregnancies; and
11
12 Whereas, Injectable contraceptives are more than 99% effective when given on time; and
13
14 Whereas, The necessity of clinic visits every three months is a barrier for many women to
15 access this form of contraception; and
16
17 Whereas, Other forms of injectable medications have been trusted to patients, such as insulin,
18 migraine medications, and fertility treatments, among others; and
19
20 Whereas, Multiple studies have found women prefer to do contraceptive injections themselves
21 as opposed to visiting an office and have maintained similar efficacy as compared to in-office
22 treatment; and
23
24 Whereas, There is now a sub-cutaneous form of injectable contraceptive treatment available
25 with the same efficacy as intramuscular injections, allowing easier and less painful use by
26 patients at home; therefore be it
27
28 RESOLVED, That our American Medical Association support access to at-home contraceptive
29 injections as a method of birth control for women across the nation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

RELEVANT AMA POLICY

Development and Approval of New Contraceptives H-75.990

Our AMA: (1) supports efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA.
Citation: BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

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;

Over-the-Counter Access to Oral Contraceptives D-75.995

Our AMA: (1) encourages the US Food and Drug Administration to approve a switch in status from prescription to over-the-counter for oral contraceptives, without age restriction; (2) encourages the continued study of issues relevant to over-the-counter access for oral contraceptives; and (3) will work with expert stakeholders to advocate for the availability of hormonal contraception as an over-the-counter medication.
Citation: Sub. Res. 507, A-13; Modified: BOT Rep. 10, A-18; Modified: Res. 518, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 521
(A-23)

Introduced by: Illinois

Subject: Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs

Referred to: Reference Committee E

Whereas, The Drug-Free Workplace Act of 1988 (41 U.S.C. 81) is an act of the United States which requires some federal contractors and all federal grantees to agree that they will provide drug-free workplaces as a precondition of receiving a contract or grant from a Federal agency; and

Whereas, Virtually all employers and municipalities follow these guidelines for their drug testing protocols even though they may not have any federal ties; and

Whereas, Cannabis metabolite (THC-COOH) analysis has been part of all urine drug testing programs since the inception of 41 U.S.C.81 in November 1988; and

Whereas, The American College of Occupational and Environmental Medicine (ACOEM) recommends that the implications for workplace safety be a primary consideration and that those in safety-sensitive identified positions should be held to a higher standard until a scientifically valid method to identify impairment has been developed; and

Whereas, Cannabis can significantly impair judgment, motor coordination, and reaction time; and

Whereas, It is well documented that persons experiencing impairment from any drug or medication tend to underestimate the severity of their impairment; and

Whereas, In the first year (2020) of legalization of recreational cannabis in Illinois, more than 1100 people were killed in traffic accidents in the state – an astounding 16% increase from 2019 reversing a downward trend of fatalities over the past decade; and

Whereas, Chicago witnessed a far more dramatic spike in traffic fatalities (139 killed) – a 45% increase from 2019; and

Whereas, Traffic accidents and deaths have been documented to increase when cannabis is legalized; and

Whereas, Initiating THC use at a potency of 12% is associated with almost a fivefold higher risk for progression to cannabis use disorder symptom onset within a year; and

Whereas, THC exhibits adverse cardiac, neurological and psychiatric effects that are dose-related and therefore the use of cannabis is deemed inadvisable for persons performing safety-sensitive work; and

1 Whereas, Cannabis use also can cause violent behavior through increased aggressiveness,
2 paranoia, and personality changes (more suspicious, aggressive, and anger); therefore be it
3
4 RESOLVED, That our American Medical Association support the continued inclusion of
5 cannabis metabolite analysis in all urine/hair/oral fluid drug testing analysis performed for
6 occupational and municipal purposes (pre-employment, post-accident, random and for-cause).
7 (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 5/5/23

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RELEVANT AMA POLICY

Issues in Employee Drug Testing H-95.984

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 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.
Citation: (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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 522
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Approval Authority of the FDA

Referred to: Reference Committee E

Whereas, The Food and Drug Administration (FDA) is the agency in the executive branch charged with reviewing the science provided by the manufacturers of drugs, convening panels of medical experts in the field, reviewing the relevant medical literature, determining the safety and efficacy of drugs and devices, and approving said drugs and devices for use[1]; and

Whereas, The FDA follows a rigorous, evidence-based review process that has administrative safeguards and opportunities for dissenting views to be heard; and

Whereas, A federal district judge without any medical training or expertise has overturned an FDA decision about a drug, mifepristone, which was both deemed to be safe and effective, and the Supreme Court has maintained access to this drug by staying the district court's decision for the time being[2]; and

Whereas, The drug has been on the market for over 20 years and has been proven safe and effective[3]; and

Whereas, This precedent would allow the judicial branch to negate the procedures of the executive branch and put access to future drugs at risk without consideration of science and medical needs; and

Whereas, This precedent could also have a chilling effect on innovation, research and development if every FDA approval is considered subject to review and reversal; and

Whereas, Physicians must be able to depend on the FDA for accurate and unbiased assessments of drugs; therefore be it

RESOLVED, That our American Medical Association consider filing an amicus brief if a mifepristone-access case is formally heard at the Supreme Court to allow the Food and Drug Administration (FDA) to continue its mission of providing safe and effective drugs without political or ideological interference. (Directive to Take Action)

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

Received: 5/10/23

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3. Food and Drug Administration. Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation. (2023). https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation

RELEVANT AMA POLICY

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Citation: Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 523
(A-23)

Introduced by: Indiana

Subject: Reducing Youth Abuse of Dextromethorphan

Referred to: Reference Committee E

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1 Whereas, Prescription opioids caused nearly 16,500 deaths in 2020; and
2
3 Whereas, The U.S. Food and Drug Administration (FDA), overriding the advice of an expert
4 panel, reported in July 2012 that it would not require doctors to have special training before they
5 could prescribe long-acting prescription opioids; and
6
7 Whereas, The FDA has said companies that make the drugs would be required to underwrite
8 the cost of voluntary programs aimed at teaching doctors how to best use long-acting
9 prescription opioids; and
10
11 Whereas, Dextromethorphan (DXM) is a type of cough suppressant drug, known as an
12 antitussive, that is either prescribed or available over the counter (OTC) to treat pain, coughs,
13 colds, and several other conditions; and
14
15 Whereas, DXM is classified as an opioid, though it does not have the same effect on the brain's
16 opioid receptors as other opioids, although when taken in large doses, it does cause depressant
17 or even hallucinogenic effects; and
18
19 Whereas, Because DXM is commonly found in OTC medicines, it is rather easy to obtain,
20 especially by minors; therefore be it
21
22 RESOLVED, That our American Medical Association seek and support methods to reduce the
23 sale of products containing dextromethorphan to minors. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-23)

Introduced by: New York

Subject: Ensuring Access to Reproductive Health Services Medications

Referred to: Reference Committee E

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1 Whereas, Mifepristone is one of two drugs used for medication abortion, a protocol that has
2 been approved by the U.S. Food and Drug Administration for two decades; and
3
4 Whereas, Mifepristone is used in combination with misoprostol to end an early pregnancy; and
5
6 Whereas, Mifepristone has been safely used in the United States more than 5 million times; and
7
8 Whereas, Mifepristone is a drug approved by the FDA in 2000 for terminating pregnancies
9 through 49 days gestation; and
10
11 Whereas, Medication abortion offers many women a less invasive procedure, and medication
12 abortion regimen is supported by major medical organizations as a safe and effective method;
13 and
14
15 Whereas, The Alliance for Hippocratic Medicine v. FDA seeks to constrain the options
16 physicians are able to provide to their patients even in protected states; and
17
18 Whereas, A Texas judge on April 7, 2023 revoked the Food and Drug Administration's approval
19 of mifepristone; and
20
21 Whereas, Approval of practically every drug in the US could be undermined by a Texas court's
22 recent ruling on mifepristone, threatens the country's entire regulatory structure; and
23
24 Whereas, Both these cases represent an egregious interference in the practice of medicine and
25 impacts the patient-physician relationship; and
26
27 Whereas, The implications of this case could impact reproductive healthcare services for
28 generations to come; and
29
30 Whereas, It is highly likely that state medical associations will be asked to join litigation
31 surrounding these cases; therefore be it
32
33 RESOLVED, That our American Medical Association advocate and support the continuation of
34 the Food and Drug Administration’s authority to determine whether drugs are safe and effective
35 (Directive to Take Action); and be it further
36
37 RESOLVED, That our AMA support legal efforts to ensure that mifepristone and misoprostol are
38 available to anyone for whom they are prescribed (New HOD Policy); and be it further

1 RESOLVED, That our AMA support efforts, including joining in an Amicus Brief, to ensure that
2 both these medications continue to be available, and that the FDA retain its regulatory authority.
3 (Directive to Take Action)

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

Received: 5/10/23

RELEVANT AMA POLICY

Supporting Access to Mifepristone (Mifeprex) H-100.948

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

Citation: Res. 504, A-18; Modified: Res. 027, A-22; Reaffirmed: Res. 317, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-23)

Introduced by: Georgia, Mississippi, Oklahoma, New Jersey, Alabama, Virginia, Delaware

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates

Referred to: Reference Committee F

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1 Whereas, Our American Medical Association is the largest and only national organization that
2 convenes delegations from 190+ state and national medical specialty societies and other critical
3 stakeholders twice a year, with the mission of promoting the art and science of medicine and the
4 betterment of public health; and
5
6 Whereas, At these meetings, our AMA's policies are determined by our AMA House of
7 Delegates (HOD), which is an incredibly diverse deliberating body whose delegates bring a
8 wealth of knowledge, experience, and perspective to the debates; and
9
10 Whereas, Many of our AMA's constituent and component medical societies are facing
11 significant financial challenges—in some cases even existential; and
12
13 Whereas, In too many instances, these financial challenges are negatively affecting the
14 sponsoring societies' ability to fully fund the essential activities (travel, lodging, meals, staffing,
15 caucus expenses, etc.) of their AMA delegation members, including medical students, residents,
16 and fellows; and
17
18 Whereas, When the financial costs of participating in AMA delegation activities become the
19 personal expense obligations of the individual delegation members, this may result in an
20 unfortunate and potentially devastating reversal of the diversity of the delegation
21 representation—possibly weighting them towards older, more financially successful membership
22 and conceivably resulting in reduced medical student, resident, and fellow representation; and
23
24 Whereas, The 2021 AMA Annual Report reported over 278,000 AMA members, $34.8 Million in
25 dues receipts, consolidated revenue and income of $459.7 Million before tax, net operating
26 income of $77.9 Million, and reserves of almost $1 Billion; and
27
28 Whereas, Instituting a reimbursement policy to help state and national specialty societies fund
29 their AMA delegation HOD business meeting expenses will not significantly affect the AMA's
30 financial position while providing a critical lifeline for many of the former; therefore be it
31
32 RESOLVED, That our American Medical Association develop a reimbursement policy consistent
33 with established AMA travel policies for reasonable travel expenses that any state or national
34 specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's
35 actual expenses directly related to the necessary business functions required of its AMA
36 delegates and alternate delegates in service to the AMA at HOD meetings, including travel,
37 lodging, and meals (Directive to Take Action); and be it further

1 RESOLVED, That each state or national specialty society requesting such reimbursement for its
2 delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated
3 documentation to the AMA in whatever form is requested by the AMA. (Directive to Take Action)

Fiscal Note: This policy would result in AMA being responsible for approximately $8.1 million annually based on current AMA travel policy, estimated average costs for airfare and travel, and current number of delegates and alternate delegates.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-23)

Introduced by: Matthew D. Gold, M.D., Delegate

Subject: Enabling Sections of the American Medical Association

Referred to: Reference Committee F

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1 Whereas, The American Medical Association is the premiere single organization that represents
2 the entire spectrum of the medical profession; and
3
4 Whereas, Sections of the AMA serve as centers of association of individuals around a theme
5 regardless of residence or practice location, in contrast to State delegations which are
6 geographically limited; and
7
8 Whereas, Sections of the AMA traditionally have developed novel initiatives and serve as a
9 source of synthesis of ideas from diverse perspectives, in a setting more conducive to person to
10 person interaction than the much larger House of Delegates; and
11
12 Whereas, The financial expenditure, as well as opportunity cost (e.g., time away from practice)
13 involved in attending a Section meeting is virtually the same whether that meeting is held over
14 one or two days; and
15
16 Whereas, Restricting Section meetings to a single calendar day significantly limits the
17 opportunity for sharing of ideas, development of policy and educational sessions, and
18 enrichment of interpersonal connections; and
19
20 Whereas, Restricting Section meetings to a single calendar day reduces the opportunity for
21 Sections to interact, collaborate, and share educational sessions; and
22
23 Whereas, Compressing the Session meetings leaves those who are involved in other AMA
24 business unable fully to participate in their Sections business and activities; and
25
26 Whereas, The effect of limiting Section meetings to a single day is a disincentive to attend, at
27 least in person; therefore be it
28
29 RESOLVED, That our American Medical Association Section meetings be held officially over no
30 less than two calendar days in anticipation of general House of Delegates meetings, unless
31 otherwise determined by a given individual Section. (Directive to Take Action)

Fiscal Note: Space permitting within currently contracted venues, the incremental daily cost of expanding an AMA Section meeting beyond one day is ~$10-$12K per meeting, per section.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-23)

Introduced by: Illinois

Subject: Supporting Carbon Offset Programs for Travel for AMA Conferences

Referred to: Reference Committee F

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1 Whereas, Climate change is a grave threat facing human and planetary health and is an issue
2 that is already recognized and addressed by our American Medical Association. According to
3 the World Health Organization, it is "…the single biggest health threat facing humanity, and
4 health professionals worldwide are already responding to the health harms caused by this
5 unfolding crisis;"[1] and
6
7 Whereas, The healthcare industry, which is one of the most carbon-intensive service sectors in
8 the industrialized world, is responsible for 4.4–4.6 percent of worldwide greenhouse gas (GHG)
9 emissions, largely stemming from fossil fuel combustion[2], and
10
11 Whereas, In 2022, our AMA adopted policy to declare climate change a public health crisis and
12 advocates for policies that reduce emissions aimed at carbon neutrality and supports rapid
13 implementation in incentivization of clean energy solutions and significant investments in climate
14 resilience through a climate justice lens (D-135.966, *Declaring Climate Change a Public Health*
15 *Crisis*); and
16
17 Whereas, Our AMA supports calling on the health sector to lead by example to commit to
18 carbon neutrality by 2050 by supporting initiatives to promote environmental sustainability within
19 its business operations (D-135.966, H-135.921, *AMA to Protect Human Health from the Effects*
20 *of Climate Change by Ending its Investments in Fossil Fuel Companies*, and H-135.923, *AMA*
21 *Advocacy for Environmental Sustainability and Climate*); and
22
23 Whereas, Carbon offsetting is "the act of reducing carbon dioxide or greenhouse gases in order
24 to compensate for emissions that were produced elsewhere;"[3] and
25
26 Whereas, Our AMA has resumed in-person meetings, allowing for enhanced didactic sessions,
27 colleague interaction and efficient discussion and advancement of relevant and timely policy
28 impacting the healthcare profession and public health. These conferences require air and
29 ground travel for hundreds of participants, amounting to thousands of tons of greenhouse gas
30 emissions; and
31
32 Whereas, Carbon pollution from transportation is due to burning fossil fuels such as gasoline
33 and diesel, releasing GHG into the atmosphere, and such emissions from transportation are the
34 largest contributor of U.S. GHG emissions, accounting for about 27%[4]; and
35
36 Whereas, Carbon-neutral procurement and other purchasing options or equivalent carbon
37 offsets are a mechanism to mitigate such emissions; therefore be it
38
39 RESOLVED, That our American Medical Association facilitate the mitigation or offset of carbon
40 emissions related to AMA events, including planning and management, travel, and conference

1 operations, by procurement of sustainable or otherwise carbon-neutral energy, travel services,
2 supplies, etc. under the direct control of the AMA and provision for conference attendees and
3 other external stakeholders to access the equivalent mitigation or offsets for their own
4 attendance and related activities. Mitigation and offset measures may include purchase of
5 renewable energy credits, sustainable purchasing requirements integrating emissions criteria,
6 investment in forestry and conservation, energy efficiency projects, or other instruments traded
7 by accredited entities. (Directive to Take Action)

Fiscal Note: 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 carbon credits to offset AMA emissions, including, among others, making mitigation efforts accessible to attendees. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

Received: 5/5/23

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RELEVANT AMA POLICY

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Citation: Res. 420, A-22;

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;

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;

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;

Referral Change:
Was Resolution 506

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-23)

Introduced by: Medical Student Section

Subject: Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development

Referred to: Reference Committee F

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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 innovation[1],
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 innovation[1],
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 research[1];
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 acceptance[2]; 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 aim[5]; 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 solutions[6]; 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 entrepreneurs[8]; 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 innovation[9],
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 base[10]; 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 physiciansprofessional 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 patientsand other individualsprivacy 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: 710
(A-23)

Introduced by: Michigan

Subject: Protect Patients with Medical Debt Burden

Referred to: Reference Committee G

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1 Whereas, It is estimated that the percentage of American adults with medical debt range from
2 17.8 percent to 35 percent; and
3
4 Whereas, The Consumer Financial Protection Bureau reports $88 billion in medical debt on
5 consumer credit records as of June, 2021; and
6
7 Whereas, It is estimated that approximately 23 million adults owe over $250 in unpaid medical
8 bills; with more than 70 percent owing over $1,000 and about half owing more than $2,000; and
9
10 Whereas, People with medical debt are far less likely to fill a prescription, see a specialist when
11 needed, visit a doctor or clinic for a medical problem and more likely to skip a needed test,
12 treatment, or follow-up visit; and
13
14 Whereas, Out of every 100 people in the U.S., between 18 and 35 people have medical debt in
15 collections, with Black, Indigenous, and people of color and people with lower incomes having
16 higher rates of medical debt than the general population; and
17
18 Whereas, The COVID-19 pandemic brought renewed attention to medical debt, health
19 inequities, and public health; therefore be it
20
21 RESOLVED, That our American Medical Association work with the appropriate national
22 organizations to address the medical debt crisis by advocating for robust policies at the federal
23 and state level that prevent medical debt, help consumers avoid court involvement, and ensure
24 that court involved cases do not result in devastating consequences to patients' employment,
25 physical health, mental wellbeing, housing, and economic stability. (Directive to Take Action)

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

Received: 5/8/23

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RELEVANT AMA POLICY

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996
Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.
Citation: Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20;

Health Plan Payment of Patient Cost-Sharing D-180.979
Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
Citation: CMS Rep. 09, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-23)

Introduced by: Missouri

Subject: Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to *Dobbs*

Referred to: Reference Committee G

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1 Whereas, U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* led
2 to the enactment of previously passed state legislation (known as "trigger laws") in many states
3 hindering the provision of abortion services; and
4
5 Whereas, Unlike federal law, many of these state statutes are ambiguous regarding the
6 definition of "emergency condition" that allow a physician to render pregnancy-related care; and
7
8 Whereas, The federal Emergency Medical Treatment and Active Labor law (EMTALA) governs
9 the obligations of physicians and facilities where pregnancy-related care is rendered and
10 supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States
11 Constitution; and
12
13 Whereas, EMTALA codifies that an emergency medical condition is defined to exist *upon the*
14 *recognition of the threat* of loss of life or loss of function of any bodily system, an event that
15 often occurs before "unstable" vital signs have developed consequent to the emergency
16 condition; and
17
18 Whereas, In some cases, physicians complying with EMTALA will be forced to violate the
19 recently enacted "trigger laws" and can be charged with a crime; and
20
21 Whereas, Insurers typically terminate liability insurance coverage for physicians who have been
22 charged with a criminal offense, especially if the alleged offense is classified as a felony; and,
23
24 Whereas, Hospitals, medical clinics, and other health care facilities typically terminate a
25 physician's medical staff membership and clinical privileges when a physician has been charged
26 with a criminal offense, especially if the alleged offense is classified as a felony; therefore be it
27
28 RESOLVED, That the American Medical Association work with medical liability insurers and
29 medical care facilities to discourage the termination of liability coverage or clinical privileges of
30 any physician who has been charged with a crime arising from the provision of evidence-based
31 healthcare. (Directive to Take Action)

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

Received: 5/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-23)

Introduced by: New Jersey

Subject: Medical Bankruptcy – A Unique Feature in the USA

Referred to: Reference Committee G

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1 Whereas, In 2020, medical debt was $429 million across the United States; and
2
3 Whereas, The United States is the only developed nation that has such an enormous medical
4 debt; and
5
6 Whereas, In this country medical bills are the most common reason for bankruptcy. 17% of
7 adults with health care debt had to declare bankruptcy or lose their home because of it in 2022;
8 and
9
10 Whereas, The United States already has the most expensive health care of any country, despite
11 the medical bankruptcies; and
12
13 Whereas, The average age of a medial bankruptcy filer is 44.9 years old and 66.5% of all
14 bankruptcies are caused directly by medical debt, making it the leading cause for bankruptcy;
15 and
16
17 Whereas, Projections by the Centers for Medicare and Medicaid Services project that
18 healthcare expenditures will increase 50% by 2028, to 6.2 trillion dollars; and
19
20 Whereas, In 2019 Americans borrowed an estimated $90 billion to pay for health care; and
21
22 Whereas, On average, couples that retire at age 65 pay a total of $275,000 in medical bills for
23 the remainder of their life; and
24
25 Whereas, About 51% of single-person households with private insurance reported they would
26 be unable to pay a $6,000 medical bill. 32% reported they would be unable to pay a $2000
27 medical bill; and
28
29 Whereas, Americans health care expenses account for nearly 20% of GDP, which is almost
30 double that of most other developed countries. From 2000 to 2019, annual health insurance
31 premiums increased by approximately 50%; and
32
33 Whereas, According to the Organization for Economic Cooperation and Development, higher
34 out-of-pocket costs have been shown to translate to worse health outcomes. These costs cover
35 everything paid for directly by an individual, including prescription drug and physician visit
36 copays, health insurance deductibles and medical goods for personal use. Higher out-of-pocket
37 medical costs can deter someone with a medical problem from seeking treatment; and

1 Whereas, Americans had a life expectancy at birth of 78.6 years, which is lower than nearly all
2 developed countries. For example, France has a life expectancy at birth of 82.6 years, four
3 years longer than the United States; and
4
5 Whereas, In 2018 America's total healthcare bill, including spending on government programs,
6 private health insurance, and patients' out-of-pocket costs exceeded $10,000 per person, which
7 was more than twice what governments, insurers, and patients in the Netherlands, Canada,
8 France, and the United Kingdom spent, and almost twice Germany's healthcare costs; and
9
10 Whereas, In the rest of the developed world, medical costs are rarely or never cited as a driver
11 behind personal bankruptcy; therefore be it
12
13 RESOLVED, That our American Medical Association study the causes of medical bankruptcy in
14 the United States and draft a report for presentation at the 2024 Annual House of Delegates
15 meeting, with such report to include recommendations to the House of Delegates to severely
16 reduce the problem of medical debt. (Directive to take action)

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

Received: 5/4/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-23)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Redesigning the Medicare Hospice Benefit

Referred to: Reference Committee G

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1 Whereas, The population of terminally ill patients enrolled under the Medicare hospice benefit
2 today is very different than in 1983 when the benefit was established, with Alzheimer's disease
3 and related dementias (ADRD) representing a growing portion of hospice enrollees. And with
4 changing primary diagnoses, the care needs for these patients are also much different today[1];
5 and
6
7 Whereas, It has been shown that patients with ADRD can derive significant benefits from
8 hospice care, yet a 2022 study published in *JAMA Health Forum* found that current Medicare
9 policies aimed at reducing hospice misuse and long lengths of stay pose concerns for reduced
10 utilization by patients with ADRD – given the unpredictable trajectory of dementia – which may be
11 associated with poorer end-of-life experience and outcomes for these patients[2-5]; and
12
13 Whereas, Electing the hospice benefit means waiving access to all other Medicare services
14 related to the terminal condition, consequently the desire to continue disease-directed care or
15 certain intensive palliative treatments outside the usual scope of hospice care results in too
16 many patients who do not access hospice services until the last hours or days of life – or not at
17 all – depriving them and their families/caregivers of the supportive care to which they are
18 entitled; and
19
20 Whereas, For many patients belonging to historically minoritized or marginalized groups, a
21 history of discrimination, structural inequities, and substandard service delivery has resulted in a
22 lack of trust in the medical system associated with a reduced willingness to forgo life-sustaining
23 care and lower enrollment in hospice, as confirmed by a 2020 study published in *JAMA Network*
24 *Open* showing "despite the increase in the use of hospice care in recent decades, racial
25 disparities in the use of hospice remain, especially for noncancer deaths"[1,6]; and
26
27 Whereas, Some aspects of the Medicare hospice benefit drive disparities in access to vital
28 services that can improve care and quality of life for seriously ill beneficiaries. For example, the
29 benefit was designed with the assumption that a patient has caregivers available at home; thus,
30 patients who lack home resources, transportation, and/or caregiver availability, or are otherwise
31 socially isolated, simply may not elect the benefit[7]; and
32
33 Whereas, The payment structure of the Medicare hospice benefit contributes to reduced access
34 to hospice care in rural settings given that rural providers receive lower payments compared to
35 urban hospice providers, despite facing increased costs due to travel distances and greater
36 difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages;
37 and
38
39 Whereas, Council on Medical Services Report 4-I-16 recommends "that our AMA support
40 continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a

1 variety of models for providing and paying for concurrent hospice, palliative and curative care";
2 and

3 Whereas, In light of the above, policymakers should reconsider the hospice benefit, and pursue
4 efforts to redesign, establish, and implement an equitable, anti-racist benefit utilizing a process
5 that is inclusive, transparent, and iterative; therefore be it
6
7 RESOLVED, That Our American Medical Association advocate for a 21st century evolution of
8 the Medicare hospice benefit that meets the quadruple aim of health care; advances health
9 equity; and improves access, support, and outcomes for seriously ill patients across all
10 geographies, including underserved and low-resource communities (Directive to Take Action);
11 and be it further
12
13 RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that incorporates
14 the following components:
15
16 1) Hospice eligibility should not be based solely on a specified prognosis or life expectancy
17 but rather on patients' needs; patients with unclear prognoses should be able to access
18 hospice services if their need is otherwise established.
19 2) Patients must continue to have an open choice of hospice providers.
20 3) Hospice services, including telehealth or telemedicine, should be provided by a full,
21 physician-led interdisciplinary team.
22 4) Patients and their caregivers should receive adequate support using home- or facility-
23 based hospice services, identified by a thorough assessment of their social determinants
24 of health. This would incorporate 24-hour a day care for beneficiaries with very limited
25 life expectancy who lack around-the-clock caregivers.
26 5) Patients should have concurrent access to disease-directed treatments along with
27 palliative services.
28 6) Payments to hospices should be sufficient to support the quality, experience, scope, and
29 frequency of care that beneficiaries deserve throughout the later stages of serious illness
30 as dictated by their physical, psychological, social, spiritual, and practical needs.
31 7) The hospice benefit should be consistent, including with regard to the quality and
32 intensity of services, regardless of which Medicare program or entity pays for services.
33 8) Metrics for health provider accountability should focus on those aspects of care and
34 experience that matter most to patients, families, and caregivers.
35 (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.
Citation: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18;

Hospice Care H-85.955
Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22;

Hospice Coverage and Underutilization H-85.966
The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.
Citation: Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21;

End-of-Life Care H-85.949
Our AMA supports: (1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit; (2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition; and (3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
Citation: CMS Rep. 1, I-21;

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.
(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.
(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.
(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.
(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-23)

Introduced by: American Academy of Hospice & Palliative Medicine

Subject: Improving Hospice Program Integrity

Referred to: Reference Committee G

Whereas, Recent investigations show disproportionate hospice growth in some states with no clear correlation to need, along with unusual billing and operational activity – including to indicate some hospices are being established primarily for the purpose of selling them for profit – suggesting willful fraud or abuse of the hospice benefit; and

Whereas, Medicare data has shown excessive geographic clustering of hospices (in one case, 120 separately licensed agencies in California are located in the same building, 75 of which are Medicare certified); and

Whereas, After a statewide moratorium on new hospice licenses was enacted in California in 2022, similar troubling activity is shown to have spread to nearby states, including Arizona, Nevada, and Texas; and

Whereas, Medicare beneficiaries nearing the end-of-life need – and deserve – all the valuable services that good hospice delivers; and

Whereas, Patients and families who engage with fraudulent hospices can suffer real and lasting consequences, including not receiving the types or level of care they need, or in some cases, any care at all; and

Whereas, The many hospice audits currently in place have no bearing on care quality, nor have they been shown to significantly curtail inappropriate organizational behavior; and

Whereas, Policy interventions aimed at ensuring hospice program integrity and quality should:

- Center on the needs of hospice patients and their families to ensure an optimal care experience.
- Ensure timely and equitable access to hospice care across all geographies and communities.
- Focus on integrity and quality indicators that impact patient care rather than focusing on technical errors.
- Target non-operational and low-performing programs while avoiding blunt instruments that could unnecessarily burden high-performing programs.
- Promote education and training of hospice professionals and support the free exercise of reasonable, independent judgment in clinical decisions made in good faith, including certification of terminal illness; and

Whereas, Current AMA policy calls to "ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals,

1 hospices, and rehabilitation facilities (H-160.975, *Planning and Delivery of Health Care*
2 *Services*); therefore be it
3
4 RESOLVED, That Our American Medical Association advocate that the Centers for Medicare &
5 Medicaid Services (CMS) use its existing authority to limit certification of additional hospices in
6 counties where growth in hospice programs is out of line with established need by implementing
7 a temporary targeted moratorium based on federal and state data, allowing for appropriate
8 exceptions to ensure continued access to care (Directive to Take Action); and be it further
9
10 RESOLVED, That Our AMA advocate that CMS strengthen investigation prior to approval of
11 initial hospice certification applications and, for those new hospices approved but identified as
12 high risk, require enhanced scrutiny and/or survey frequency (Directive to Take Action); and be
13 it further
14
15 RESOLVED, That our AMA advocate that CMS use its existing authority to prohibit the sale or
16 transfer of Medicare hospice certification numbers for a specified timeframe (similar to the 36-
17 month change of ownership prohibition in the Medicare home health program), allowing for
18 appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it
19 further
20
21 RESOLVED, That Our AMA advocate that CMS restrict Medicare privileges for non-operational
22 hospices, including through voluntary termination of the provider agreement, deactivation of
23 billing privileges, and revocation of Medicare enrollment (Directive to Take Action); and be it
24 further
25
26 RESOLVED, That Our AMA advocate that CMS regulatory efforts aimed at weeding out fraud,
27 waste, and abuse be refocused on integrity and quality indicators that impact patient care –
28 rather than technical errors and retrospective chart audits focused on questioning eligibility –
29 and avoid blunt instruments that burden high-performing programs, divert time and resources
30 from patient care, and risk driving smaller providers from the market and/or putting rural or
31 frontier hospice programs at a disadvantage. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent **hospice**, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.

3. Our AMA encourages physicians to be familiar with local **hospice** and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.
Citation: (CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18)

Hospice Care H-85.955

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care;
(2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment;
(3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;
(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program;
(5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers;
(6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and
(7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.
Citation: (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22)

Hospice Coverage and Underutilization H-85.966

The policy of the AMA is that:
(1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy;
(2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease;
(3) Appropriate active palliation should be a covered hospital benefit; and
(4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.
Citation: (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21)

End-of-Life Care H-85.949

Our AMA supports:
(1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's **hospice** benefit;
(2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's **hospice** and skilled nursing facility (SNF) benefits for the same condition; and
(3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
Citation: (CMS Rep. 1, I-21)

Planning and Delivery of Health Care Services H-160.975

(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser

and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.
(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.
(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.
(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.
(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.
Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Published Metrics for Hospitals and Hospital Systems

Referred to: Reference Committee G

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1 Whereas, American health care has witnessed an explosion in the number of hospital
2 administrators; and
3
4 Whereas, Studies have shown hospital boards are largely devoid of clinicians;[1] and
5
6 Whereas, The number of physicians who have become employed by hospitals has grown in
7 recent years, with 74% of physicians now employed by a hospital, health system or corporate
8 entity;[2] and
9
10 Whereas, While the C-Suite has significantly expanded, physicians have faced many negative
11 changes to the practice of medicine, including Medicare cuts, increased regulatory burdens and
12 crushing "burnout," which have driven many to leave practice or curtail the hours they devote to
13 patient care; and
14
15 Whereas, While physicians are subject to scrutiny and oversight, these same requirements are
16 not placed on hospitals and health systems; and
17
18 Whereas, Hospital administrators are increasingly responsible for contributing to the high
19 turnover of talented, well-trained clinicians; and
20
21 Whereas, While hospitals are subject to publicly available measures citing such data as
22 infection rates, physicians do not have access to measures about the hospital as a workplace
23 environment, such as how physician-friendly the environment is; and
24
25 Whereas, Existing employee-based websites, such as GlassDoor.com, do not have the ability to
26 provide physicians the granular information needed to evaluate the hospital environment
27 relevant to physicians; therefore be it
28
29 RESOLVED, That our American Medical Association identify transparency metrics, such as
30 physician retention and physician satisfaction, that would apply to hospitals and hospital
31 systems and report back with recommendations for implementing appropriate processes to
32 require the development and public release of such transparency metrics. (Directive to Take
33 Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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2. Physicians Advocacy Institute. 2022. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Referred to: Reference Committee G

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1 Whereas, There has been tremendous health care consolidation over the last several years,
2 with hospital systems acquiring multiple hospitals and physician practices; and
3
4 Whereas, The size of these transactions has been increasing, with $1 billion deals involved;[1]
5 and
6
7 Whereas, According to the Medicare Payment Advisory Commission, by 2017, in most markets,
8 a single hospital system accounted for more than 50 percent of inpatient admissions; and
9
10 Whereas, As hospital systems grow, the bureaucracy and administration of these systems grow
11 while competition decreases; and
12
13 Whereas, Burdens placed upon physicians, such as non-compete clauses, limit the ability of
14 physicians to leave or challenge the system's dominance; and
15
16 Whereas, There have been several high-profile examples of physicians who have raised patient
17 care concerns and have been targeted by the hospital system;[2] and
18
19 Whereas, Regulatory bodies, such as The Joint Commission, do not currently track or hold
20 accountable hospital systems for the mistreatment of physicians; therefore be it
21
22 RESOLVED, That our American Medical Association identify options for developing and
23 implementing processes — including increased transparency of physician complaints made to
24 the Equal Employment Opportunity Commission and The Joint Commission — for tracking and
25 monitoring physician complaints against hospitals and hospitals systems and report back with
26 recommendations for implementing such processes, including potential revisions to the Health
27 Care Quality Improvement Act of 1986 to include monetary penalties for institutions performing
28 bad-faith peer reviews. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 5/10/23

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2. Geoff, Kelly. Yet another Roswell lawsuit alleging bias. Investigative Post. Feb. 27, 2023. https://www.investigativepost.org/2023/02/27/yet-another-roswell-lawsuit-alleging-bias/.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-23)

Introduced by: American College of Chest Physicians

Subject: Improving Patient Access to Supplemental Oxygen Therapies

Referred to: Reference Committee G

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1 Whereas, More than 1.5 million Americans use supplemental oxygen, a therapy that can
2 improve the quality of life for adults living with chronic lung diseases[1-3]; and
3
4 Whereas, Advocacy groups, health care professionals, and patients report with alarming
5 frequency inaccurate coverage denials related to home oxygen; and
6
7 Whereas, The burden of these implementation gaps, and denials falls on the patients and their
8 providers; and
9
10 Whereas, The Centers for Medicare and Medicaid Services (CMS) in September 2021
11 published a new National Coverage Decision Memo on Home Use of Oxygen and Oxygen Use
12 to Treat Cluster Headaches which replaced the Certificate of Medical Necessity with medical
13 record review for documentation of necessity of supplemental oxygen; and
14
15 Whereas, During the COVID related public health emergency, CMS suspended physician
16 medical record review in recognition that hospital surges made it impossible for physician's
17 records to accurately reflect all the information required by Medicare Recovery Audit
18 Contractors; and
19
20 Whereas, During the period of suspension of medical record review no significant increase in
21 fraud and abuse was recognized; and
22
23 Whereas, In the opinion of our organization, relying on medical review to establish supplemental
24 oxygen medical necessity will introduce complexity, inconsistency, delays, and unneeded costs
25 to the system without benefit; therefore be it
26
27 RESOLVED, That our American Medical Association advocate for the adoption of a CMS-
28 crafted, patient- and provider- endorsed, clinical template in lieu of medical record review to
29 maintain patient access to supplemental oxygen (Directive to Take Action); and be it further
30
31 RESOLVED, That our AMA, to ensure predictable reimbursement and establish medical
32 necessity, advocate for CMS to establish a CMS-crafted, patient- and provider- endorsed,
33 clinical template as the national standard documentation for supplemental oxygen suppliers.
34 (Directive to Take Action)

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

Received: 5/10/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718
(A-23)

Introduced by: Georgia

Subject: Insurance Coverage of FDA Approved Medications and Devices

Referred to: Reference Committee G

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1 Whereas, Health insurers are increasingly denying coverage per their policy letters claiming
2 medications and devices are experimental; and
3
4 Whereas, Physicians and staff are spending increasing time on peer to peer calls trying to
5 obtain approval for their patient's care; and
6
7 Whereas, Insurance companies are practicing medicine without a license by denying care
8 recommended by licensed physicians; therefore be it
9
10 RESOLVED, That our American Medical Association support prohibiting the use of the rationale
11 for denial that a medication or device is experimental by insurance companies where such
12 medication or device has been approved by the United States Food and Drug Administration for
13 one year or longer and has peer-reviewed evidence supporting its use in the manner in which it
14 was prescribed. (New HOD Policy)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719
(A-23)

Introduced by: Illinois

Subject: Care Partner Access to Medical Records

Referred to: Reference Committee G

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1 Whereas, Many people manage their health with the help of others including family members
2 and friends, who are often referred to as informal care partners (or caregivers), and the role of
3 these care partners can include arranging and attending medical appointments, participating in
4 medical decision-making, coordinating services and addressing various patient needs; and
5
6 Whereas, Despite the vital role played by care partners, they are often unable to access health
7 information in the electronic health record (EHR) that is necessary to coordinate and manage
8 care; and
9
10 Whereas, One study revealed that only two-thirds of the U.S. hospitals surveyed offered adult
11 patients the option of granting portal access to a care partner, and among hospitals that did, the
12 process for obtaining proxy credentials was often difficult and time consuming; and
13
14 Whereas, Shared access to a patient's medical portal can improve patient and family
15 satisfaction with care, improve agreement with goals of care and treatment decisions, care
16 partner confidence in managing care and can help reduce care partner burden; and
17
18 Whereas, Few healthcare organizations have a convenient and straightforward procedure for
19 granting proxy access, and even when EHR vendors offer mechanisms for access, healthcare
20 organizations appear to give little thought to the information needs of this group; and
21
22 Whereas, Using secure patient portals to link care partners to the healthcare team should be a
23 priority for healthcare organizations; therefore be it
24
25 RESOLVED, That our American Medical Association advocate that electronic health records
26 (EHR) vendors offer simplified procedures for granting proxy access to care partners (or
27 caregivers) to the electronic health record, including online registration with multifactor
28 authentication to promote security, rather than requiring in person registration (Directive to Take
29 Action); and be it further
30
31 RESOLVED, That our AMA advocate that vendors develop a simple mechanism for noting and
32 displaying care partner names and contact information in the Electronic Health Record (EHR),
33 along with privacy settings that allow patients to grant proxy access to selected portions of their
34 records, including easy to understand information on use of this information and a user-friendly
35 consent mechanism (Directive to Take Action); and be it further
36
37 RESOLVED, That our AMA support and encourage Congress to modernize Health Insurance
38 Portability and Accountability Act (HIPAA) laws to ensure that HIPAA rules for preserving the
39 privacy of patient and associated data also cover third party applications' access to electronic
40 health records (EHRs). (New HOD Policy)

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

Received: 5/5/23

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;

Confidentiality of Computerized Patient Records H-315.990
The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; and (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties' use of computerized patient records in physicians' offices.
Citation: Res. 813, I-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Modified: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Prior Authorization Costs, AMA Update to CMS

Referred to: Reference Committee G

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1 Whereas, The impact of prior authorization costs is becoming excessive as an unfunded
2 mandate on practices; and
3
4 Whereas, The study by our American Medical Association has shown that practices must
5 complete 41 prior authorizations per physician each week on average, which consumes almost
6 two business days of physician and staff time, with 40% of physicians reporting that they have
7 hired staff who work exclusively on prior authorizations[1]; and
8
9 Whereas, ASCO conducted a survey of members and found that nearly all survey participants
10 report patient harm including disease progression (80%) and loss of life (36%)[2]; and
11
12 Whereas, Our AMA will submit practice expense data and methodology information collected
13 via a physician practice expense survey to begin in June 2023 to the Centers for Medicare &
14 Medicaid Services (CMS) as they make updates; therefore be it
15
16 RESOLVED, That our American Medical Association include the costs associated with prior
17 authorization in the practice expense data and methodology information submitted to the
18 Centers for Medicare & Medicaid Services. (Directive to Take Action)

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

Received: 5/10/23

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2. Nearly All Oncology Providers Report Prior Authorization Causing Delayed Care, Other Patient Harms. *The ASCO Post*. December 25, 2022. https://ascopost.com/issues/december-25-2022/nearly-all-oncology-providers-report-prior-authorization-causing-delayed-care-other-patient-harms/

RELEVANT AMA POLICY

Update Practice Expense Component of Relative Value Units D-406.992
Our American Medical Association will conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services (CMS) to update the resource-based relative value practice expense methodology.
Citation: BOT Action in response to referred for decision Res. 131, A-19;

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721
(A-23)

Introduced by: American Society for Gastrointestinal Endoscopy, American Academy of Physical Medicine and Rehabilitation, American College of Gastroenterology, American Gastroenterological Association, American Society for Surgery of the Hand Professional Organization, American Society of Echocardiography, North American Spine Society, Society for Cardiovascular, Angiography & Interventions

Subject: Use of Artificial Intelligence for Prior Authorization

Referred to: Reference Committee G

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1 Whereas, Health insurers are adopting artificial intelligence technology to speed up prior
2 authorization decisions; and

3 Whereas, Health insurance companies are increasingly relying on artificial intelligence as a
4 more economical way to conduct prior authorization for a greater number of health care
5 services; and

6 Whereas, *ProPublica* revealed that over a period of two months in 2022, Cigna doctors denied
7 more than 300,000 claims as part of a review process that used artificial intelligence, with Cigna
8 doctors spending an average of 1.2 seconds on each case[1]; and

9 Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all
10 diagnostic and surveillance colonoscopies, upper endoscopies, and capsule endoscopies —
11 roughly 47 percent of all gastrointestinal services; and

12 Whereas, UHC has stated it uses technology that allows it to make “fast, efficient and
13 streamlined coverage decisions”[2]; and

14 Whereas, the use of artificial intelligence to review requests for prior authorization raise
15 questions about whether insurance companies are in compliance with state and federal
16 insurance regulations; and

17 RESOLVED, That our American Medical Association advocate for greater regulatory oversight of
18 the use of artificial intelligence for review of patient claims, including whether insurers are using
19 a thorough and fair process that includes reviews by doctors and other health care professionals
20 with expertise for the service under review, and that such reviews include human examination of
21 patient records prior to a care denial. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims?utm_medium=social&utm_source=twitter&utm_campaign=TwitterThread
2. Ibid.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722
(A-23)

Introduced by: New York

Subject: Expanding Protections of End-Of-Life Care

Referred to: Reference Committee G

Whereas, Despite clinical practice guidelines recommendations of ongoing assessments of pain, other symptoms, side effects of treatment, and functional capacity pain and other distressing symptoms are often undertreated and inadequately controlled[1]; and

Whereas, The medical profession increasingly recognizes the growing need to educate physicians in palliative care, however, trainee and physician awareness of and comfort with palliative care management is highly variable[2-5]; and

Whereas, Medical students receive varied training in palliative and end of life care ranging from 2 hours to weeks and most residents (81%) reported little to no classroom training on EOL care during residency[6,7]; and

Whereas, Palliative care is underutilized in the United States and the National Inpatient Sample showed that palliative care consultations were recorded in only 9.9% of 4,732,172 weighted advanced cancer hospitalizations[8]; and

Whereas, The need for palliative care and end of life symptom relief has been largely ignored as healthcare systems and medicine have focused on extending life, but not to the same extent on dignity and quality of life when curative treatment is no longer possible[5]; and

Whereas, The AMA Code of Ethics also states that "the duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients"[9]; and

Whereas, There are many ethical and legal considerations in end of life care in a climate where physicians have faced civil and criminal liability for providing standard of care end of life symptom control to patients as recently as 2022[10,11]; and

Whereas, Standard of care end of life treatment can include treatments that can decrease the level of alertness and a patients remaining hours[12]; and

Whereas, There is variability in how prosecutors, juries, and judges interpret the law in relation to medical treatment of distressing symptoms therefore it is imperative the house of medicine take a strong stance to preserve the patient physician relationship[13,14]; therefore be it

RESOLVED, That our American Medical Association:
(1) recognizes that healthcare, including end of life care like hospice, is a human right;
(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life healthcare services;

1 (3) supports the medical and public health importance of access to safe end of life healthcare
2 services and the medical, ethical, legal and psychological principles associated with end-of-life
3 care;
4 (4) supports education of physicians and lay people about the importance of offering
5 medications to treat distressing symptoms associated with end of life including dyspnea, air
6 hunger, and pain;
7 (5) will work with interested state medical societies and medical specialty societies to vigorously
8 advocate for broad, equitable access to end-of-life care;
9 (6) supports shared decision-making between patients and their physicians regarding end-of-life
10 healthcare;
11 (7) opposes limitations on access to evidence-based end of life care services;
12 (8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against
13 physicians for receiving, assisting in, referring patients to, or providing end of life healthcare
14 services. (New HOD Policy)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Good Palliative Care H-70.915
Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good

care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21;