

Reference Committee D

BOT Report(s)

- 17 AMA Public Health Strategy

CSAPH Report(s)

- 04 School Resource Officer Violence De-Escalation Training and Certification
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
- 08 Sunset Review of 2013 HOD Policies

Resolution(s)

- 401 Metered Dose Inhalers and Greenhouse Gas Emissions
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court
- 406 Increase Employment Services Funding for People with Disabilities
- 407 Addressing Inequity in Onsite Wastewater Treatment
- 408 School-to-Prison Pipeline
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
- 411 Protecting Workers During Catastrophes
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
- 415 Environmental Health Equity in Federally Subsidized Housing
- 416 New Policies to Respond to the Gun Violence Public Health Crisis
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health
- 418 Increasing the Availability of Automated External Defibrillators
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
- 420 Foster Health Care
- 421 Prescribing Guided Physical Activity for Depression and Anxiety
- 422 National Emergency for Children
- 423 Reducing Sodium Intake to Improve Public Health
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
- 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

**Contained in the Handbook Addendum*

Reference Committee D

Resolution(s)

- 430* Teens and Social Media
- 431* Qualified Immunity Reform

**Contained in the Handbook Addendum*

EXECUTIVE SUMMARY

BACKGROUND. Given the number of requests from the House of Delegates for ongoing reports on public health-related topics as well as large national campaigns, the Board of Trustees is taking this opportunity to outline the AMA's work in public health. The intent is to provide clarity on our current efforts and priorities, with regular updates on progress.

DISCUSSION. The AMA's current priorities around public health are as follows:

1. Promote evidence-based clinical and community preventive services.
 - A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.
 - B. Help prevent cardiovascular disease (CVD) by addressing major risk factors.
 - C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and LTBI.
 - D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.
2. Respond to public health crises impacting physicians, patients, and the public.
 - A. Address the public health crisis of climate change.
 - B. Prevent firearm injuries and deaths.
 - C. Respond to emerging and reemerging infectious disease threats and prepare for future pandemics.
 - D. End the nation's drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
 - A. Strengthen physician and trainee knowledge of public health and social determinants of health.
 - B. Maintain AMA relationships with national public health organizations.
 - C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.
4. Combat the spread of misinformation and disinformation.
 - A. Make evidence-based medical and public health information accessible.
 - B. Combat public health disinformation that undermines public health initiatives.
 - C. Collaborate with scientific and health organizations to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-23

Subject: AMA Public Health Strategy

Presented by: Sandra A. Fryhofer, MD, Chair

Referred to: Reference Committee D

1 BACKGROUND

2
3 Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public
4 Health Systems” adopted by House of Delegates (HOD) at I-21 directed our American Medical
5 Association (AMA) to:

6
7 develop an organization-wide strategy on public health including ways in which the
8 AMA can strengthen the health and public health system infrastructure and report
9 back regularly on progress.

10
11 Policy D-135.966, “Declaring Climate Change a Public Health Crisis,” adopted by the
12 House of Delegates at A-22 directed our AMA to:

13
14 develop a strategic plan for how we will enact our climate change policies including
15 advocacy priorities and strategies to decarbonize physician practices and the health
16 sector with report back to the House of Delegates at the 2023 Annual Meeting.

17
18 Resolution 605-A-22, “Fulfilling Medicine’s Social Contract with Humanity in the Face
19 of the Climate Health Crisis” was referred by the House of Delegates and asked the AMA
20 to:

21
22 establish a climate crisis campaign that will distribute evidence-based information on
23 the relationship between climate change and human health, determine high-yield
24 advocacy and leadership opportunities for physicians, and centralize our AMA’s
25 efforts towards environmental justice and an equitable transition to a net-zero carbon
26 society by 2050.

27
28 Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis”
29 has also called for the AMA to:

30
31 report annually to the House of Delegates on our AMA’s efforts relating to
32 legislation, regulation, and litigation at the federal, state, and local levels to prevent
33 gun violence.

34
35 Given the number of requests from the HOD for ongoing reports on public health-related
36 topics as well as large national campaigns, the Board of Trustees is taking this
37 opportunity to outline the AMA’s work in public health, so the HOD has clarity on

current efforts and priorities. Our intent is to provide regular updates on the status of this work to the HOD.

METHODS

This report is informed semi-structured, in-depth interviews with public health and physician experts (n=17), members of the AMA Board of Trustees (n=11), and members of the AMA's Senior Management Group (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH). Members of the AMA Board of Trustees were asked to participate in interviews at the discretion of the Board Chair. Members of the Senior Management Group were identified based on whether they reported that their work involves public health.

What is Public Health?

Since its founding in 1847, the AMA's mission has been "to promote the art and science of medicine and the betterment of public health." Through the course of the interviews conducted across stakeholders, it was clear that there are many different definitions and understanding of what public health is.

According to the World Health Organization (WHO) public health is "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society."ⁱ Public health promotes and protects the health of people and the communities where they live, learn, work and play.ⁱⁱ Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.ⁱⁱⁱ While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional's duty is to the community rather than an individual patient.

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The WHO defines health equity as the "absence of unfair and avoidable or remediable differences in health among social groups."^{iv} It calls for just opportunities, conditions, resources and power for all people to be as healthy as possible. Public health interventions and policies aim to reduce health disparities and are essential for promoting health equity and improving the health of entire populations. Opportunities and resources for health are inequitably distributed, public health seeks to right this inequity.

The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.^v

1 The five strategic approaches of the health equity strategy are highly relevant to the
2 AMA's public health work and include:

- 3
- 4 1. Embed racial and social justice throughout the AMA enterprise culture, systems,
5 policies and practices.
- 6 2. Build alliances and share power with historically marginalized and minoritized
7 physicians and other stakeholders.
- 8 3. Push upstream to address all determinants of health and the root causes of
9 inequities.
- 10 4. Ensure equitable structures and opportunities in innovation.
- 11 5. Foster pathways for truth, racial healing, reconciliation and transformation for the
12 AMA's past.
- 13

14 The AMA already develops an annual report on health equity activities. While integral to the
15 AMA's public health strategy, progress towards the health equity strategy will continue to be
16 reported in the BOT's annual health equity report. (See BOT 10-A-23, "Center for Health Equity
17 Annual Report.")

18 19 CURRENT AMA APPROACHES TO PREVENTION & PUBLIC HEALTH

20 21 **1. Promote evidence-based clinical and community preventive services.**

22
23 Clinical preventive services involve the care provided by physicians and other health care
24 professionals during a routine one-to-one encounter.^{vi} They have a strong evidence base for
25 efficacy in health improvement and/or cost-effectiveness. These services are not public health, but
26 rather clinical care. However, they are included here because they are necessary to achieve the
27 goals of public health. Community preventive services are evidence-based options that decision
28 makers and affected community members can consider when determining what best meets the
29 specific needs, preferences, available resources, and constraints of their jurisdictions and
30 constituents.^{vii} They are not oriented to a single patient or all of the patients within a practice. The
31 target is an entire population or subpopulation usually identified by a geographic area.^{viii}

32
33 A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory
34 Committee on Immunization Practices (ACIP), and the Community Preventive Services Task
35 Force (CPSTF) and support the dissemination of recommendations to physicians.

36
37 The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national
38 experts in disease prevention and evidence-based medicine. The Task Force works to improve the
39 health of people nationwide by making evidence-based recommendations about clinical preventive
40 services. The AMA is USPSTF Dissemination and Implementation (D&I) partner, through which
41 we contribute expertise by helping disseminate the work of the task force to physician members to
42 help put the recommendations into practice.^{ix} Partners are also a powerful vehicle for ensuring the
43 U.S. primary care workforce remains up to date on USPSTF recommendations.

44
45 The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health
46 experts who develop recommendations on the use of vaccines in the civilian population of the
47 United States. The recommendations stand as public health guidance for safe use of vaccines and
48 related biological products. In addition to the voting members, there are 30 non-voting
49 representatives from professional organizations, including the AMA, that are highly regarded in the
50 health field.^x These members comment on ACIP's recommendations and offer the perspectives of
51 groups that will implement the recommendations.

The Community Preventive Services Task Force (CPSTF) is an independent, non-federal panel whose members are appointed by the CDC Director. CPSTF members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health. The CPSTF was convened in 1996 by the Department of Health and Human Services (HHS) to identify community preventive programs, services, and policies that increase health, longevity, save lives and dollars, and improve Americans' quality of life. The CPSTF's recommendations, along with the systematic reviews of the evidence on which they are based, are compiled in the *The Community Guide*. The AMA serves as an organizational liaison to the CPSTF.^{xi}

B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes Group)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. In collaboration with health care leaders and organizations, the AMA is developing and disseminating new chronic disease prevention and management approaches. Our primary focus is cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for 1 in 4 deaths.^{xii,xiii} The AMA engages in this work through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

Two major risk factors for CVD are hypertension and type 2 diabetes. An estimated 116 million adults have hypertension and 96 million have prediabetes which can lead to hypertension.^{xiv,xv} Obesity also leads to the development of cardiovascular disease and cardiovascular disease mortality independently of other cardiovascular risk factors.^{xvi} To help prevent Type 2 diabetes, the AMA developed clinical practice tools that support the screening and managing of people with prediabetes in alignment with clinical guidelines. The AMA also developed AMA MAP BPTM, a clinical quality improvement program that includes population dashboards and reports as well as coaching, training and support for clinical teams. IHO provides the AMA MAP BP program to health care delivery organizations and other collaborators to support improvement in blood pressure control for patients. The AMA MAPTM framework is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and type 2 diabetes. The AMA is examining how to integrate obesity into its chronic disease portfolio. It completed a landscape assessment to identify existing opportunities and will convene an expert panel to review recommendations from the landscape assessment to provide guidance.

Additionally, in response to the high prevalence of uncontrolled blood pressure and to support physicians in managing their patients' high blood pressure, the AMA, in collaboration with the American Heart Association, developed Target: BPTM, a national initiative offering a series of online resources, using the latest evidence-based information. Target: BP recognizes organizations committed to improving blood pressure control. In 2022, the program recognized 1,309 health care organizations (HCO) for their efforts in representing 49 states or U.S. territories and serving more than 28 million patients, including 8.1 million people with hypertension.

Black, Latinx, Indigenous, Asian/Pacific Islanders, and other people of color are disproportionately impacted by CVD risk factors and resulting morbidity and mortalities.^{xvii} To better address these disparities the AMA partnered with the American College of Preventive Medicine and Black Women's Health Imperative to increase Black and Latinx women's enrollment in the CDC's National Diabetes Prevention Program lifestyle change program.

The AMA, along with physician groups and heart health experts, launched the Release the Pressure (RTP) campaign.^{xviii} The campaign has reached over 300,000 Black women, encouraging them to

pledge to “know your numbers, talk with your doctor, bring your squad,” in addition to training 75,000 individuals to track their blood pressure via self-monitoring blood pressure tracking tools.

C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI).

Through funding from the CDC, the AMA has been engaged in work on a project entitled, “Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings.” The scope of this project includes developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and latent TB infection.

As a first phase of this work, the AMA conducted in-depth interviews, virtual clinic visits and co-creation groups with clinicians working in organizations where a well-defined routine screening process is already in place in order to better understand best practices, key challenges and critical considerations when implementing a routine screening program. The findings from these sessions were synthesized and used as the framework to build out the toolkit and its key recommendations.

The toolkit consists of a series of webpages on the AMA’s corporate website. Information and recommendations are organized along the screening and testing continuum and offer helpful resources and best practices from the AMA, CDC and other organizations. The resources include a mix of both implementation and training-related materials for the care team. It is intended to be flexible, allowing an organization to follow along throughout the entire continuum to help improve the end-to-end screening and testing approach or narrow in and focus on a specific stage where additional guidance and support may be needed. Two versions of the toolkit are being developed—one targeted to community health centers and a second to emergency departments.

In order to validate the initial iteration of the community health center toolkit that was developed, the AMA conducted a pilot with a cohort of 6 community health centers across the country.^{xix} This work included pilot sites implementing 2-3 toolkit recommendation during the pilot period as well as participating in a series of 5 telementoring sessions with other pilot sites, with each session being focused on a different section of the toolkit. A second pilot to test elements of the toolkit in practice is planned to take place in the spring of 2023 with a cohort of emergency departments. Following these pilots, any feedback and comments received from pilot sites will be prioritized and incorporated into the toolkit before the toolkit is launched more broadly.

D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

While the AMA’s primary audience is physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that we have to prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.

1. Get My Flu Shot

The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. The *Get*

My Flu Shot campaign PSAs are launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. The campaign ads direct audiences to [GetMyFluShot.org](https://www.getmyflushot.org) for more information, including where to get a flu vaccine in their area.

2. It's Up to You

The Ad Council and COVID Collaborative, including the AMA, led a massive communications effort to educate the American public and build confidence around the COVID-19 vaccines. Guided by the leading minds in science and medicine and fueled by the best talent in the private sector, the COVID-19 Vaccine Education Initiative is designed to reach different audiences, including communities of color who have been disproportionately affected by COVID-19. Under the umbrella of the "It's Up to You" campaign, we worked to ensure that Americans have accurate and timely information to answer their questions and concerns about vaccine side effects, efficacy, and clinical trials. The goal being to shift the public mindset from vaccine concern to vaccine confidence.

3. Do I have Prediabetes

More than one in three American adults have prediabetes and are at high risk of developing type 2 diabetes—a serious health condition that can lead to heart attack or stroke. Of these individuals, more than 80% of people with prediabetes don't know they have it. However, the vast majority of people with prediabetes can take steps to reduce their risk. Prediabetes can often be reversed through weight loss, diet changes, and increased physical activity. The AMA, in collaboration with the CDC developed a series of PSAs encouraging viewers to visit [DoIHavePrediabetes.org](https://www.doihaveprediabetes.org), where they can take a one-minute risk test to highlight the importance of early diagnosis and speaking with their physician. Over 12.5M risk tests have been completed since 2016.

4. Get Down with Your Blood Pressure

Nearly half of all American adults have high blood pressure, yet only about 1 in 4 individuals have their condition under control. Because of the pandemic and persisting health inequities, there is an increased risk of high blood in communities of color, particularly for Black, Hispanic/Latinx, and Native American adults. The AMA and AHA "Get Down With Your Blood Pressure" campaign teaches adults that self-monitoring their blood pressure is as easy as four simple steps: get it, slip it, cuff it, check it. Along with talking to your health care provider about a blood pressure management plan, taking these steps can decrease the incidence of stroke, heart attack, and heart failure. The AMA in collaboration with the AHA maintain both [ManageYourBP.org](https://www.manageyourbp.org) or [BajaTuPresion.org](https://www.baja BUPresion.org) which host tools and resources to help educate patients about the how to self-monitor your blood pressure and speak to your health care provider.

2. Responding to public health crises impacting physicians, patients, and the public.

The AMA's public health work has also been focused around responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's response to public health crises are typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

A. Address the public health crisis of climate change.

At 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate change a public health crisis that threatens the health and well-being of all individuals.” At I-22, the Council on Science and Public Health presented a council-initiated report on this topic “due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted.” That report noted the health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health. The report’s recommendations, which were adopted by the HOD called for a reduction in US greenhouse gas (GHG) emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. In the coming year the AMA’s priorities will be as follows:

1. Educate physicians and trainees on the health effects of climate change.

The AMA has made climate change education available via the Ed HubTM from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). However, the AMA has not developed a CME module for physicians and trainees on climate change, that will be an area of focus over the coming year.

2. Identify and disseminate information to physicians on decarbonizing the health care sector and reducing GHG emissions.

The U.S. health sector accounts for 25 percent of global health sector emissions, the highest proportion attributable to any individual country’s health sector. The Joint Commission is in the process of convening a technical advisory panel to initiate a directional standard that encourages health systems to address reducing their own carbon footprint, and to review existing standards to be sure, explicitly, that they do not require excess consumption. With the goal of reducing U.S. GHG emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, the AMA will create a resource page to share information on high-impact actions needed to decarbonize the health care sector.

There are several resources that already exist including Health Care Without Harm’s Road Map that provides a plan to get health care toward zero emissions.^{xx} The Road Map identifies seven high-impact actions as key to health care decarbonization. Agency for Healthcare Research and Quality (AHRQ) and Institute for Healthcare Improvement’s primer that offers guidance on high-priority measures and strategies for health care organizations to reduce their carbon footprint.^{xxi} The primer describes six domains contributing to GHG emissions in health care: building energy, transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and food. To meaningfully track and reduce GHG emissions, the primer recommends health care organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized standard for quantifying and reporting on emissions. The National Academy of Medicine’s Action Collaborative on Decarbonizing the U.S. Health Sector has also hosted a series of Carbon Clinics designed for health care delivery organizations to learn about carbon accounting. The Carbon Clinics will soon be made public along with related resources.

3. Elevate the voices of physician leaders on the issue of climate change and health.

Through the AMA’s video updates and podcast series, we amplify physician voices and highlight developments and achievements throughout medicine. On January 20, 2022, the AMA featured Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who discussed research on the intersection of health and the climate crisis.^{xxii} On August 25, 2022, the AMA featured Colin Cave, MD, medical director of external affairs, government relations and community health, Northwest Permanente to discuss the link between health and climate change, and how physicians and health systems can be a part of the solution.^{xxiii} The AMA will continue to look for opportunities to highlight physicians doing this important work.

4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

Medical Society Consortium on Climate and Health. The AMA will continue to engage in the Medical Society Consortium on Climate and Health (Consortium), which brings together associations representing over 600,000 clinical practitioners to carry three simple messages:

- A. Climate change is harming Americans today and these harms will increase unless we act;
- B. The way to slow or stop these harms is to decrease the use of fossil fuels and increase energy efficiency and use of clean energy sources; and
- C. These changes in energy choices will improve the quality of our air and water and bring immediate health benefits.^{xxiv}

The Consortium recognizes that medical societies have an important opportunity to weigh in to help ensure that the health risks of climate change and the health benefits of climate solutions, especially clean energy, are clearly understood. The voices of America’s medical societies have the potential to help reframe the dialogue – putting human health and wellbeing front and center in the conversation. This is especially important to communities who are experiencing a disproportionate impact from climate change.

National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector. The AMA is also a member of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Climate Collaborative is a public-private partnership of leaders from across the health system committed to addressing the sector’s environmental impact while strengthening its sustainability and resilience. The Climate Collaborative provides a neutral platform for its participants to align around collective goals and actions for decarbonization, based on evidence, shared solutions, and a commitment to improve health equity.^{xxv}

In the first year of the Climate Collaborative, the Health Care Delivery Workgroup has focused on the following goals:

- Goal 1: Make the multi-faceted case for health systems and hospitals to minimize their carbon footprints and operate more sustainably;
- Goal 2: Identify a set of policy and regulatory barriers preventing progress on decarbonization and resilience from accelerating, and identify solutions;
- Goal 3: Identify a core set of sustainability metrics for hospitals and clinical practice;
- Goal 4: Develop decarbonization playbooks and best practices for hospitals and health care delivery institutions, leveraging existing frameworks and success stories.

At the time of this report, the Health Care Delivery Workgroup is in the final stages of building consensus around goals for 2023.

1
2 Healthy Air Partners. The AMA has joined the American Lung Association's Healthy Air Partners
3 campaign, which is a coalition of 40 national public health, medical, nursing and health care
4 organizations engaged in healthy air advocacy efforts.^{xxvi} The Coalition is united in its calling for
5 strong federal laws and policies to slash air pollution and address climate change, recognizing
6 climate change can affect air quality, and certain air pollutants can affect climate change. So far in
7 2023, the AMA has joined partners on a letter to the EPA urging them to quickly strengthen and
8 finalize the Standards of Performance for New, Reconstructed, and Modified Sources and
9 Emissions Guidelines for Existing Sources: Oil and Natural Gas Sector so that implementation can
10 begin and communities can begin to see the benefits of the pollution reductions.^{xxvii}
11

12 The Inflation Reduction Act (IRA), which was signed into law on August 16, 2022, was the most
13 significant measure ever adopted by the U.S. Congress to combat climate change. The IRA is likely
14 to play an important role in mitigating the adverse health effects of climate change. Implementation
15 of the IRA will require extensive rulemaking; therefore, we anticipate that to be the focus of our
16 advocacy efforts in the coming year.
17

18 B. Prevent firearm injuries and deaths. 19

20 In the 1980's the AMA recognized firearms as a serious threat to the public's health as the weapons
21 are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual
22 Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence
23 represents a public health crisis which requires a comprehensive public health response and
24 solution." Since that time firearm injuries and deaths have increased and disparities have
25 widened.^{xxviii}
26

27 1. Educate physicians on how to counsel at risk patients on firearm injury prevention and what 28 steps to take if a patient is at risk. 29

30 In 2018, the AMA created a CME module with physician experts on "The Physician's Role in
31 Firearm Safety." The learning objectives of the module are as follows: (1) Describe the
32 epidemiology of firearm morbidity and mortality in the U.S.; (2) Recognize common risk factors
33 that elevate the potential for firearm injury; (3) Identify barriers to communicating with patients
34 about firearm safety; (4) Determine practical approaches to prepare for firearm safety counseling;
35 and (5) Effectively communicate how to reduce the risk of firearm injury and death.^{xxix} The module
36 had 619 completions from 2019 - 2023 and has an overall quality rating of 4.4/5.0. The AMA is
37 currently in the process of updating the information in the module and will add a new case study
38 around dementia and firearms. The updated version is expected to launch in May of 2023. We
39 recognize that a broader dissemination strategy of the updated module will be necessary to improve
40 uptake among health care professionals.
41

42 Along with the updated CME, the AMA will launch an online tool to provide physicians with state-
43 specific laws in their jurisdiction related to counseling restrictions, safe storage and child access
44 protection laws, temporary transfer requirements, and extreme risk protection orders. This
45 information will help guide physicians when they identify patients at risk of firearm injury and
46 death by sharing details on what is allowed under state law.
47

48 2. Advocate for common sense policies to prevent firearm injuries and increased funding for 49 research. 50

51 Congress succeeded in passing the first major firearm legislation in over 30 years with

1 S. 2938, the “Bipartisan Safer Communities Act” (Murphy, D-CT/Cornyn, R-TX), which the AMA
2 supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair
3 Sandra Adamson Fryhofer, MD, attended the signing ceremony. Key provisions of the bill
4 include:

- 5
- 6 • Providing grants for states to establish or strengthen extreme risk protection orders;
- 7 • Adding convicted domestic violence abusers in dating relationships to the National Instant
- 8 Criminal Background Check System (NICS);
- 9 • Requiring the NICS to contact authorities to see whether an individual under the age of 21
- 10 has a “disqualifying” juvenile record for buying a firearm;
- 11 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited
- 12 from doing so; and
- 13 • Including new spending for school security and mental health treatment.
- 14

15 Our AMA is now focused on advocating to ensure that the new funding authorized in the new law
16 is actually appropriated, advocating for states to establish or strengthen extreme risk protection
17 orders, and ensuring that the other provisions are properly and quickly implemented. Pursuant to
18 the new law, the Department of Justice recently awarded over \$200 million in grants to states,
19 territories, and the District of Columbia to fund state crisis intervention court proceedings,
20 including but not limited to, extreme risk protection order (ERPO) programs that work to keep
21 guns out of the hands of those who pose a threat to themselves or others.

22
23 The AMA has also advocated for Congress to appropriate increased funding for research to prevent
24 firearm violence. The AMA is working with medical specialties, including the American Academy
25 of Pediatrics, to support \$60 million in funding for the CDC and the National Institutes of Health
26 (NIH) to conduct public health research on firearm morbidity and mortality prevention. This would
27 double the amount of funding provided last year. Our AMA will continue to monitor appropriations
28 developments and advocate to ensure that this funding is approved by Congress.

29
30 Through the AMA’s litigation center, we work to represent the interests of the medical profession
31 on this issue in the courts by providing support or becoming actively involved in litigation of
32 importance to physicians. The AMA has created a website broadly outlining the organization’s
33 advocacy efforts on gun violence prevention, this includes cases for which the AMA has filed
34 amicus briefs.^{xxx}

35
36 3. Elevate the voices of physician leaders on the issue of firearm injury and violence prevention.

37
38 Through the AMA’s video updates and podcast series, we amplify physician voices and highlight
39 developments and achievements throughout medicine. In June of 2022, the AMA featured Megan
40 Ranney MD, MPH, a practicing emergency physician, researcher and national advocate for
41 innovative approaches to public health at Brown University, talking about gun violence and why
42 we need to approach it as a public health issue with physicians playing an important role.^{xxxi} On
43 February 23, 2023, Emmy Betz, MD, MPH, professor of emergency medicine and director of the
44 Firearm Injury Prevention Initiative at the University of Colorado School of Medicine was featured
45 to discuss firearm-related injury and suicide and the role physicians can play in helping to prevent
46 it.^{xxxii} AMA leaders, including Immediate Past President Gerald Harmon, MD, have also talked
47 about firearm injuries and deaths being a public health crisis that can affect everybody and that
48 requires a comprehensive public health response and a solution.^{xxxiii}

4. Collaborate across the federation of medicine and with other interested partners to address the public health crisis of firearm injuries and deaths with a unified voice.

American Foundation for Firearm Injury Reduction in Medicine. The AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM combines the health expertise with the knowledge and traditions of responsible firearm stewardship to achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries and deaths. AFFIRM at The Aspen Institute also builds partnerships with non-medical organizations that are equally committed to preventing firearm injury, including groups committed to firearm safety and shooting sports.

ACP-Led Call to Action on Firearm-Related Injury and Death. The AMA has joined the American College of Physicians (ACP), American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons (ACS), American Psychiatric Association, and the American Public Health Association in calling for policies to help stem firearms-related injuries and deaths in the United States. The organizations endorsed the article, "Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations."^{xxxiv}

Medical Summits and Coalition for Firearm Injury Prevention. The AMA also participated in a 2019 meeting on firearm violence organized by ACS and participated in a follow-up Medical Summit on Firearm Injury Prevention sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians, and the Council of Medical Specialty Societies in September of 2022. The objectives of the 2022 summit were to use a consensus-based, non-partisan approach to selecting recommendations for executive action and/or legislation at the federal, state, and municipal levels that would decrease firearm-related injuries and identify elements of the most effective programs that can be implemented by physician practices/clinics/hospitals/health systems in partnership with their communities to effectively lower the risk of violence, with an emphasis on marginalized communities that are disproportionately impacted by violence. The Summit included representatives from 46 organizations, making it one of the largest gatherings of medical and injury prevention professionals on this issue. The proceedings of the Summit were published in the *Journal of the American College of Surgeons*.^{xxxv} To achieve the goals outlined at the Summit, the sponsoring organizations agreed to establish the Healthcare Coalition for Firearm Injury Prevention.^{xxxvi}

AMA convened task force. On February 27, 2023, the AMA convened Phase I of the gun violence task force, which consisted of those Federation members who have been most highly engaged on the issue of firearm injury prevention for many years. Representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Psychiatric Association met with members of the AMA Board and staff. AMA Board Chair Sandra Adamson Fryhofer, MD, Chair of the first phase of this Task Force, led the meeting. The goal was to better understand work already underway to address this issue, what has worked well, and the unique role an AMA convened task force could play. Gun violence advocacy organizations (Brady, Giffords, and the Johns Hopkins Center for Gun Violence Solutions) were also invited to share their perspectives on the role of physicians and organized medicine in firearm injury prevention. The advocacy groups strongly encouraged organized medicine to pick one or two things to focus on and to speak on them with a unified voice.

C. Respond to emerging and reemerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to be a threat to the U.S. population. Although some diseases have been conquered by modern advances such as antibiotics and vaccines, new ones are constantly emerging, whereas others reemerge in drug-resistant forms (e.g., malaria, tuberculosis, and bacterial pneumonias). Because no one knows what new diseases will emerge, the health system must be prepared for the unexpected. Because the AMA is relied upon as a source of information by physicians and patients, the AMA has to maintain a level of capacity to respond and share information and advocate for physicians, patients, and the public in line with AMA policies. Over the course of the past few years, this work has focused heavily on responding to the COVID-19 pandemic and the outbreak of monkeypox (mpox).

1. Educate physicians on how to protect themselves and their patients from infectious disease threats.

The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.^{xxxvii} Resources are designed to empower and enable health care professionals to think critically about infection control, using adult learning principles, educational best practices, CDC recommendations, and the science that informs them. Project Firstline encourages all health care professionals to take advantage of these free infection control training resources – that were developed with health care professionals, specifically for health care professionals. For COVID-19 and mpox, the AMA also developed resource centers to share information on testing, therapeutics, and vaccines along with the latest clinical information.

2. Address preparedness for future infectious disease outbreaks and pandemics.

With over 1,000,000 individuals in the U.S. who have died as a result of COVID-19, it is critical that we evaluate shortcomings and successes and provide evidence-based guidelines to protect our patients and the public from COVID-19 and other future infectious pathogens. Given the challenges that patients, physicians, hospitals, health care facilities, and our communities have endured and continue to experience, we need to work to remedy the problems experienced during the COVID-19 pandemic regarding effective testing strategies, timely directives on appropriate utilization of public health mitigation strategies, evidence-supported efforts to maintain strategic stockpiles of personal protective equipment, ventilators, and other supplies, and to inform future health system preparedness.

D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

1. Educate physicians on overdose prevention, substance use treatment, and pain management.

The AMA makes education available to physicians on this topic via the AMA Ed HubTM to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment. Courses are both developed by AMA as well as by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides

evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.^{xxxviii}

2. Promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

The AMA has also developed an End the Epidemic Dashboard which compiles state-level data for several indicators, including overdose mortality, non-fatal overdoses, opioid prescriptions, and prescription drug monitoring program queries.^{xxxix} The dashboard also highlights which states are missing data for any of the indicators. The goal of this dashboard is to continue to promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

3. Convene the AMA Substance Use and Pain Care Task Force to advance evidence-based recommendations for policymakers and physicians, including harm reduction strategies.

In 2015, the American Medical Association convened more than 25 national, state, specialty and other health care associations to develop industry-wide recommendations for physicians to help end the nation's opioid epidemic. In 2019, the AMA Pain Care Task Force highlighted efforts needed to help patients with pain. In 2021, the AMA joined the two task forces to address the changing—and worsening—drug overdose epidemic, emphasizing tangible actions needed to increase access to evidence-based care for patients. The task force, under the leadership of Bobby Mukkamala, MD, Immediate Past Chair of the AMA Board of Trustees, continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose epidemic. The task force recommendations are largely focused in the health care sector, addressing access to treatment.^{xl} Recommendation 4 is focused on public health and harm reduction.

- Recommendation 1: Support patients with pain, mental illness or a substance use disorder (SUD) by building an evidence-based, sustainable and resilient infrastructure and health care workforce.
- Recommendation 2: Remove barriers to evidence-based treatment for SUDs, cooccurring mental illness and pain.
- Recommendation 3: Support coverage for, access to, and payment of comprehensive, multi-disciplinary, multi-modal evidence-based treatment for patients with pain, a substance use disorder or mental illness.
- Recommendation 4: Broaden public health and harm reduction strategies to save lives from overdose, limit the spread of infectious disease, eliminate stigma and reduce harms for people who use drugs and other substances.
- Recommendation 5: Improve stakeholder and multi-sector collaboration in an effort to ensure that the patients, policymakers, employers, and communities benefit from evidence-based decisions.

The AMA develops an annual report on the overdose epidemic outlining accomplishments and what still needs to be done.^{xli}

4. Collaborate with external stakeholders to address the opioid addiction crisis.

The AMA is a member of the National Academy of Medicine (NAM) Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative was formed in 2018 as a public-

private partnership to foster greater coordination and collective action across the health system and beyond in addressing the opioid addiction crisis.^{xlii} The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

The Action Collaborative conducts its work around four core priority areas: Health Professional Education and Training; Pain Management Guidelines and Evidence Standards; Prevention, Treatment, and Recovery Services; and Research, Data, and Metrics Needs. The Action Collaborative produces discussion papers to advance the field and accelerate action where the evidence dictates; conducts outreach; and leads convenings, webinars, and other special events to accelerate the translation of the most promising opportunities to reverse the opioid crisis.

3. Strengthen the health system through improved collaboration between medicine and public health.

A. Strengthen physician and trainee knowledge of public health and social determinants of health.

The AMA makes education on public health and health equity available on the AMA Ed HubTM to empower individuals and organizations, in health care and beyond, in advancing health equity and the betterment of public health. The Ed Hub contains curated education from trusted sources on a wide range of public health issues. The AMA's Center for Health Equity has developed educational content to empower individuals and organizations, in health care and beyond, in advancing racial justice and equity.^{xliii}

The AMA is transforming medical education across the continuum and collaborating with undergraduate and graduate medical education institutions to create a system that trains physicians to meet the needs of today's patients and anticipate future changes. This includes working with schools to implement instruction in health systems science (HSS), the third pillar of medical education, along with the basic and clinical sciences. The HSS curriculum includes issues related to how social determinants of health affect the entire population and the improvement strategies at the population health level to address gaps in care such as the organized assessment, monitoring or measurement of key health metrics necessary to improve health outcomes for a group of individuals.^{xliv}

B. Maintain AMA relationships with national public health organizations.

The Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), and the American Public Health Association (APHA) are all designated liaisons to the Council on Science and Public Health. AMA staff are engaged in regular discussions to understand their perspectives and opportunities for collaboration.

C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.

A new health care industry consortium has agreed to work together, in partnership with public health, to focus on strengthening the interface between public health and health care. The consortium includes some of the most prominent and influential organizations from the health care sector. Core membership organizations will include: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), American Medical Association (AMA), and Kaiser Permanente (KP).

The consortium, which will be governed by senior leaders from each of the core member organizations and staffed by independent policy analysts and other experts, will focus on areas where there is significant opportunity for consensus building and where health care partners are uniquely positioned to play a significant role in advancing the work. The consortium has agreed to focus its initial work on four specific priorities and will work over the coming months to further define concrete, pragmatic, and tangible actions to advance these priorities.

Priority Actions Areas will include.

- 1) Formalizing agreements and supporting coordinated efforts between public health and health care with clear communication of goals, roles, responsibilities, tasks, and deliverables.
- 2) Evolving and supporting robust scalable emergency preparedness programs.
- 3) Establishing national standards, processes and use cases for stratifying public health and health care data by sociodemographic variables to identify disproportionate health impacts and outcomes at the community level.
- 4) Modernizing and integrating an infectious disease surveillance system that unifies data across sectors, agencies, and data systems, including novel data sources (e.g., social media) and advanced analysis methods.

4. Combat the spread of misinformation and disinformation.

At the 2022 Annual Meeting of the HOD, the Board’s report on, “Addressing Public Health Disinformation Disseminated by Health Professionals” was adopted. AMA Policy, D-440.914, “Addressing Public Health Disinformation Disseminated by Health Professionals,” outlines a comprehensive strategy to address health-related disinformation disseminated by health professionals. Aspects most relevant to public health include the following:

A. Maintaining AMA as a trusted source of evidence-based information for physicians and patients.

While the public’s trust in many institutions has waned during the COVID-19 pandemic, people generally still trust their doctors. In his November 12, 2021, address to the AMA House of Delegates, AMA CEO/EVP James Madara, MD, noted that, “[t]he AMA exists to benefit the public, but we do so in a very particular way—by being the physicians’ powerful ally in patient care. We serve the public by serving those who care for the public. Supporting physicians and improving our nation’s health has been our focus since 1847.”^{xlv}

B. Combat public health mis- and disinformation that undermines public health initiatives.

The AMA has continued to issue press statements, noting the harm of mis- and disinformation and has urged the CEOs of six leading social media and e-commerce companies to assist the effort by combatting misinformation and disinformation on their platforms. The AMA has remained a source of trusted information providing physicians with up-to-date information on public health issues.

C. Collaborate with stakeholders to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

The AMA has engaged in several collaborates to address mis- and disinformation. The recently announced Coalition for Trust in Health and Science brings together reputable associations representing academics, researchers, scientists, doctors, nurses, pharmacists, drug and insurance

1 companies, consumer advocates, and public health professionals.^{xlvi} The coalition will support
2 efforts to advance people's scientific and health literacy, earn public trust and improve health
3 outcomes and health equity as well as to correct misinformation and counter disinformation that
4 threatens health and well-being. The AMA has also been engaged with the work led by NAM,
5 WHO, and the Council of Medical Specialty Societies on a project focused on identifying credible
6 sources of health information in social media.^{xlvii}

7 8 CONCLUSION

9
10 The strategy outlined provides an overview of the work the AMA is doing in public health and
11 indicates our current priorities. While much of this work resides in Health, Science and Ethics,
12 other business units lead portions of this work including Improving Health Outcomes, the Center
13 for Health Equity and Medical Education. Advocacy, Communications, the Ed Hub team,
14 Marketing and Member Experience are also vital to advancing these efforts. Many of the public
15 health crises being addressed by the AMA are not going to be solved by our organization alone.
16 Collaboration is going to be critical, and the AMA has taken steps to engage other organizations in
17 this work where it makes sense. While there are many areas where the AMA is asked to engage,
18 the areas outlined above represent our focus in advancing the AMA's mission towards the
19 betterment of public health.

20 21 RECOMMENDATION

22
23 The Board of Trustees recommends that the following be adopted in lieu of Resolution 605-A-22
24 and the remainder of the report be filed.

- 25
26 1. Our AMA will distribute evidence-based information on the relationship between climate
27 change and human health through existing platforms and communications channels,
28 identify advocacy and leadership opportunities to elevate the voices of physicians on the
29 public health crisis of climate change, and centralize our AMA's efforts towards
30 environmental justice and an equitable transition to a net-zero carbon society by 2050.
31 (New HOD Policy)

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REPORT 04 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
School Resource Officer Violence De-escalation Training and Certification
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 416-A-22, referred for study by the House of Delegates, asked that our American Medical Association study the efficacy of School Resource Officer violence de-escalation training and certification.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “school resource officer”, “school-based law enforcement,” and “school resource officers AND training”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped full-time law enforcement officer, trained in school-based law enforcement and crisis response, assigned to work in the school using community-oriented policing concepts. Recently, the number of SROs has skyrocketed. Opponents to SROs argue that they damage school climate, criminalize relatively trivial student behavior, and fuel the school-to-prison pipeline. While proponents argue that SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models, and law-related educators for students.

SRO officers may receive training in, among other things, mental health awareness, adolescent development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis intervention, cultural competence, and school-specific topics. However, within school systems, trainings vary in content and delivery. One intervention, which has limited support in the research literature, is the use of de-escalation techniques and training for educational entities to mitigate the impact of peer aggression and promote the safety of the school environment.

CONCLUSION. This report recognizes that SROs are part of the school staff at large and should not be considered a separate entity from school counselors, social workers, school psychologists, nurses, and schoolteachers. The recommendations support the need for their roles to be defined within the team structure of the school and also supports the use of community-based policing practices to ensure that the community plays a role in prioritizing and addressing public safety. The current evidence is inconclusive on the effectiveness of de-escalation training for SROs. However, research shows that multi-faceted interventions are more likely to be effective, especially in school settings. Further, the recommendations support establishing an agreed-upon operating protocol or memorandum of understanding (MOU) that includes provisions addressing daily interactions between students and school personnel with SROs.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 04-A-23

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

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

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2 Medical Association study the efficacy of School Resource Officer violence de-escalation training
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4 5 BACKGROUND

6
7 A school resource officer (SRO) is a carefully selected, specifically trained, and properly equipped
8 full-time law enforcement officer, trained in school-based law enforcement and crisis response,
9 assigned to work in the school using community-oriented policing concepts.¹ Recently, the number
10 of SROs has skyrocketed. An estimated 14,000 to 20,000 SROs now work in schools, and the
11 number continues to grow.² Opponents argue that SROs damage school climate, criminalize
12 relatively trivial student behavior, and fuel the school-to-prison pipeline.³ Proponents argue that
13 SROs promote school safety, respond quickly to emergencies, and serve as mentors, role models,
14 and law-related educators for students. One report concluded that for every dollar invested in the
15 program, a minimum of \$11.13 of social and economic value was created.⁴

16
17 SRO officers may receive training in, among other things, mental health awareness, adolescent
18 development and communication, implicit bias, trauma-informed care, conflict de-escalation, crisis
19 intervention, cultural competence, and school-specific topics.⁵ However, within school systems,
20 trainings vary in content and delivery. For example, some training courses include information on
21 evaluation of the de-escalation and crisis response (e.g., support for staff and students after an
22 incident). Further, some training may be a stand-alone curriculum, whereas others may include de-
23 escalation as a topic within other training topics (e.g., classroom management, discipline policy,
24 academic planning).

25
26 One main intervention, which has limited support in the research literature, is the use of de-
27 escalation techniques and trainings for educational entities to mitigate the impact of peer
28 aggression and promote the safety of the school environment.⁶ Across various professional fields,
29 such as public health and education, de-escalation training involves learning strategies for the
30 prevention and the management of aggression and violence. De-escalation may include training in
31 early intervention practices, communication methods (i.e., verbal and non-verbal styles),
32 appropriate responses in potentially violent situations, and the correct use of physical intervention
33 techniques (e.g., restraint techniques, protection). The training is intended to reduce conflict,
34 aggression, and harm. In an educational setting, de-escalation can be defined as a range of
35 interconnected interventions that include verbal and non-verbal communication, self-regulation
36 assessment, and actions taken while maintaining the safety of the those in the school.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “school resource officer”, “school-based law enforcement,” and “school resource officers AND training”. Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

What are SROs?

The only definition of SRO in current federal law appears under the authorizing legislation for the Office of Community Oriented Policing Services (COPS Office), which is a component of the U.S. Department of Justice responsible for advancing the practice of community policing primarily through grant resources. This statute defines an SRO as “a career law enforcement officer, with sworn authority, deployed in community-oriented policing, and assigned by the employing police department or agency to work in collaboration with schools and community-based organizations.”⁷ Although specific responsibilities and functions of SROs vary from place to place, the “triad” concept of school-based policing divides SRO responsibilities into three main areas of: teacher, informal counselor, and law enforcement officer.⁸

History of SROs

Since the 1900s, U.S. public schools have employed a growing number of SROs. In 1975, only 1 percent of schools reported having police officers on site, but by 2018, approximately 58 percent of schools had at least one sworn law enforcement official present during the school week.⁹ In response to school shootings in the 1990s, federal and state legislation spurred this rapid proliferation of SROs.

The first use of SROs in schools is reported to have been in Flint, Michigan, in the early 1950s.¹⁰ While police have had a presence in schools since then, it has only been over the past 20 years that the practice of assigning police officers to schools on a full-time basis has become more widespread. The number of SROs expanded significantly beginning in the 1990s due to legislative initiatives in response to concerns over a series of school shootings including the Columbine tragedy. The 1994 reauthorization of the Elementary and Secondary Education Act (ESEA) included provisions that established school safety as a core focus for the U.S. Department of Education (U.S. DOE).¹¹ It also included the Safe and Drug-Free Schools and Communities Act, which authorized federal support for police in schools via a grant program wherein local education agencies could use funds to hire and train SROs.^{7,12} Between 1994 and 2009, up to 40 percent of federal funding for this act could be used to hire and train school police and support other security measures.¹³ Overall, since 1998, the federal government has invested over \$1 billion to explicitly increase police presence in schools, and over \$14 billion to advance community policing, which can include SROs.^{10,14}

In recent years, federal funding and support for SROs has increased following tragic school shootings. Despite their concerns about the unintended negative consequences of SROs, the Obama Administration renewed funding to increase the number of SROs across the country after the 2012 shooting at Sandy Hook Elementary School in Newtown, Connecticut.¹⁵ Following the 2018

1 shooting at Marjory Stoneman Douglas High School in Parkland, Florida, the Trump
2 Administration prioritized SRO positions in selecting COPS grants recipients.¹⁶

3 *Federal Policy on SROs*

4
5 Despite their growth and the substantial federal funding, there is very little federal policy explicitly
6 defining the role of SROs. The absence of SROs from federal educational policy is in part due to
7 the Obama administration's concerns over unintended negative consequences of police presence in
8 schools.¹⁷ The vagueness of federal law has led to large variation in the role, expectations, and
9 accountability of police in schools. Moreover, federal-level data collection on SROs is also
10 severely lacking. SROs are not required to register with any national database, police departments
11 are not required to report how many of their officers work as SROs, and school systems are not
12 required to report how many SROs they employ.¹ Since 2013-2014, the U.S. Department of
13 Education has collected survey data every other year that details the number of student referrals
14 and arrests made by school police (including SROs) in public schools, and which students are most
15 affected.¹⁸ The data also include the number of counselors, social workers, school psychologists,
16 and nurses that are in a school compared to the number of SROs.¹⁹ Given this overall lack of
17 descriptive data there is little information on the roles of SROs nationally or how, if at all, SROs
18 are trained. By failing to collect these data, it is difficult to monitor and evaluate the work of SROs
19 and their impact.

20
21 *State Policy on SROs*

22
23 Federal policy and accompanied funding initiatives fueled the growth of SROs programs which are
24 now operated in all 50 states.^{14,19} Yet, the lack of federal law on SROs has led to a patchwork of
25 state policy. Out of all 50 states and Washington D.C., only 26 jurisdictions specifically define
26 SRO in state statutes or regulations.¹⁹ These state-level definitions do not specify the role of SROs
27 in schools. Most states encourage schools or districts to enter into a Memorandum of
28 Understanding (MOU) with local law enforcement if they provide an SRO. For example,
29 Connecticut, Massachusetts, Ohio, and South Carolina require MOUs to outline the role of the
30 SRO.²⁰

31
32 The National Association of School Resource Officers (NASRO) suggests SROs receive at least 40
33 hours of specialized training in school policing prior to being assigned.²⁰ NASRO's Basic SRO
34 training is set up as a 5-day, 40-hour block of instruction and outlines evidence-based best
35 practices for SRO programs.²⁰ This training covers the following topics: constitutional and state
36 law, armed response, crime prevention and mitigation, interview and interrogation techniques,
37 investigations, crime prevention through environmental school design, patrol operations, advocacy
38 within the juvenile justice system, and mandatory reporting.²⁰ Twenty-eight state statutes or
39 regulations include language regarding training requirements for SROs, but these also vary widely
40 and laws in only two states specify a required length of training.²¹ In several states, the training is
41 simply what is required of traditional law enforcement, including firearm or active shooter
42 training.²² Instruction regarding how to effectively interact with youth averages around four to six
43 hours across all states.²² Training in sixteen states includes what is required of traditional law
44 enforcement in addition to school-specific training. Few states explicitly require training in de-
45 escalation or conflict resolution, mental health, youth development, or school climate.²² Only
46 Maryland and Utah explicitly include provisions for training in "implicit bias and disability and
47 diversity awareness with specific attention to racial and ethnic disparities" and "cultural
48 awareness," respectively.²² Therefore, across states there is wide variation in expectations
49 regarding SRO training. Additionally, training is primarily standard police training, with little
50 education on working in school settings and with youth.

Illinois is an example of this heterogeneity of approach. Illinois state law requires SROs to complete training within one year of assignment.²³ This training must cover juvenile developmental issues, youth mental health, how to prevent child abuse and exploitation, and various educational administrative issues. Illinois does not explicitly require implicit bias, disability training, or de-escalation training.

School District Policy on SROs

SRO training and duties vary across school districts. In general, SROs must enforce school rules and the law, as well as be visible authority figures in schools. They can also participate in mentorship programs, provide students with training on safety and violence, and promote a positive school environment.²⁴ SROs usually patrol school halls to discourage students from misbehaving, and when a student is caught breaking a school rule or the law, SROs step in to investigate and assist with student discipline. Certain school districts require SROs to follow zero tolerance policies when students are caught with drugs, meaning the SRO has zero discretion in how to respond. Other school districts allow SROs to use discretion to decide a disciplinary course of action.²²

Benefits of School Resource Officers

School resource officers can provide a variety of benefits not only to schools, but to individual students and local police departments. These benefits include promoting school safety, addressing the root causes of student misbehavior, and decreasing juvenile delinquency petitions where SROs are properly utilized.²⁵ Further, SROs can improve relationships between students and law enforcement, serve as protectors for victimized students, and reduce the burden on local law enforcement. Although there has been limited research, it is hypothesized that SROs can promote safety in schools by deterring criminal activity at schools, specifically more serious crimes including possession of a weapon and assault.²⁶ SROs can also aid in reducing the amount of fighting and bullying on campus through hallway patrols, which can allow SROs to intervene rather quickly when there is a fight.²⁶ Students may be less likely to break the rules or pick a fight when SROs are patrolling school grounds because of the increased probability of being caught.

Some districts have found that SROs can use their positions to identify the root cause of school misbehavior and help students address it. When SROs are properly utilized, they can potentially help offset the school-to-prison pipeline. For example, SROs in Franklin County, Virginia, often impose alternative methods of punishment to delinquency petitions, such as community service, school service, or mediation.²⁶ Once a student has completed his act of service, they are often encouraged to participate in afterschool extracurricular activities in order to create structure and prevent a second offense. In Franklin County, SROs only send a request for a delinquency petition to the state's attorney after all other avenues have been explored. A study of schools in this county that utilize this approach found a 64 percent decrease in potential delinquency petitions.²⁷

Research also reveals that SRO programs can improve relationships and build trust between students and law enforcement. A 2016 study that surveyed students from various schools in one southeastern U.S. school district analyzed how students' attitudes towards SROs change with increased interaction.²⁶ Overall, more student-SRO interactions were positively correlated with favorable feelings towards SROs. Other research shows that this improved trust can later help uncover previously unknown issues of abuse and neglect, because victims may feel more comfortable reporting the issue to law enforcement.²⁷ Additionally, SROs can sometimes serve as protectors for students, which can make students feel more comfortable asking for help. This is especially true for students who are victims of various crimes, abuse, and bullying, and who may feel safer attending school knowing an SRO is available to protect them.²⁷ SROs have the unique

ability to immediately intervene if a juvenile offender violates any court ordered condition, thereby increasing a victim's sense of safety at school. Finally, SROs can reduce the burden on law enforcement outside of the school. When officers are stationed at schools, the school often no longer needs to call 911 when a dangerous situation arises because it simply informs the SRO. This gives the school a quick response time while allowing patrol officers to focus on issues outside of schools. Overall, some of the benefits of SROs include:

- Increasing feelings of safety among students, teachers, and administrators,
- Deterring aggressive behavior, and empowering staff to maintain order and address behavioral issues in a timely fashion,
- Diminishing classroom time spent on discipline and behavioral disruptions,
- Improving school safety and reducing school-based crime,
- Increasing the likelihood that students report witnessing a crime, and help reduce community-wide criminality, and
- Improving relationships between law enforcement and youth.

Impacts on Safety for Marginalized Youth

In the triad model concept advanced by NASRO, in addition to their law enforcement role, SROs will act as another mentor, educator, or counselor. However, this assumption ignores the fact that Black youth, Latinx youth, immigrant youth, indigenous youth, and youth living in poverty often come to school with harmful experiences with police that may perpetuate racial inequalities in educational, health, and social outcomes.²⁸ By placing SROs in schools, these traumatic issues can be exacerbated. SROs are more likely to reproduce broader patterns of police targeting and criminalizing Black, Indigenous, Latinx, and students of color.²⁹

Further, SROs are disproportionately placed in schools serving predominantly students of color, as opposed to schools serving predominantly white populations.³⁰ Among middle and high schools where more than 75 percent of students were Black, 54.1 percent had at least one SRO or security officer on campus.^{31,32} By comparison, among middle and high schools where over 75 percent of students were white, only 32 percent had SROs.^{32,33}

SROs Are Associated with Higher Rates of Exclusionary Discipline and Criminalization

Additionally, numerous studies show that the presence of SROs in schools is associated with higher rates of exclusionary discipline (suspensions and expulsions) which increases the risk of students being pushed into the “school to prison pipeline.”³³ Students of color across the nation are disproportionately subject to these exclusionary discipline practices.³⁴ For example, in Connecticut, suspension and expulsion rates for Black and Latino male students are two to three times that of their white counterparts.³⁵ The suspension rate for Black female students is around five times that of their white counterparts.³⁶

Additionally, SROs create the potential to escalate school disciplinary issues, even minor ones, into arrestable offenses.³⁶ In one survey of SROs, 77 percent reported that they had arrested a student to calm them down and 55 percent reported arresting students for minor offenses because the teacher wanted the student to be arrested.³⁷ The majority of school-based arrests are for non-violent offenses, such as disruptive behavior.³⁹ Further, studies show that the presence of an SRO increases the number of arrests for “disorderly conduct” – an often ambiguous, and subjective characterization of behavior.³⁸ Overall, research suggests that SROs’ potential to escalate conflicts puts students at risk.³⁹ For example, schools that employed police had an arrest rate 3.5 times that

of schools without police.⁴⁰ As with exclusionary discipline, students of color are disproportionately subject to school arrests.⁴²

This pipeline extends further for undocumented students, as contact with SROs can put them at risk of detention and deportation.⁴¹ This risk is heightened in communities where local law enforcement is contracted with Immigration and Customs Enforcement under 287(g) agreements – which allows the Department of Homeland Security to deputize selected state and local law enforcement officers to enforce federal immigration law.⁴² Since 2013, COPS Grants have required recipients to sign a 287(g) agreement in order to receive funds. There are several documented cases of SROs putting immigrant students at risk of “school-to-deportation pipelines.”^{43,44}

Interference with Education

The presence of SROs and exclusionary discipline negatively impacts students’ academic achievement and can accelerate future misbehavior, truancy, and drop-out rates.⁴⁷ Students who have contact with the criminal legal system through arrests and searches experience worse schooling outcomes than those who do not. Arresting students doubles their risk of dropping out.⁴⁵ The consequences of a school arrest extend far beyond a youths’ public-school outcomes and include the loss of access to higher education and funding, job eligibility, access to public housing, and increasing both the likelihood and consequence of future law enforcement contact.⁴⁶ Further, trauma and anxiety symptoms can increase with the frequency of police contact, regardless of where that contact occurs. For many students of color, police presence in schools can cause re-traumatization given their negative experiences with law enforcement in their communities.⁵⁰

The presence of SROs can shift the focus from learning and supporting students to over-disciplining and criminalizing them. Regular police contact, even if this contact is in passing, affects how Black and Latinx youth perceive themselves, their school, and law enforcement.⁴⁷ Students of color have reported feeling the police are there to protect the school from them.⁴¹ Further, other research shows that the presence of SROs reduced students’ feelings of school connectedness – the belief that adults and peers in the school care about them as humans.^{26,48} School connectedness is an important protective factor – young people who feel connected to their school are less likely to engage in behaviors that are harmful to themselves or others and are more likely to have better academic achievement, attendance, and persistence.⁵⁰ Research also demonstrates that racial and ethnic disparities in discipline are not the consequence of differences in rates or types of misbehavior by students of color and white students but rather racial and cultural biases.⁴⁴

Lastly, the focus on SROs has also diverted attention and funds from other areas of education that could support students. Between 1999 and 2015, the percentage of students who reported security guards or assigned police officers in their schools increased from 54 percent to 70 percent while the number of school counselors increased by only 5 percent, after adjusting for the growth in student enrollment.⁴² There are also more sworn law enforcement officers than social workers in schools across the U.S., with many states employing two-to-three times as many police officers in than social workers in schools.⁴⁹ Over 4,800 schools reported employing more school police and security than school-based mental health providers.⁵³ Across the country 1.7 million students are in schools with police but no counselors; 3 million are in schools with police but no nurses; 6 million students are in schools with police but no school psychologists; 10 million students are in schools with police but no social workers.⁴² Compared to white students, Latinx, Asian, and Black students are more likely to attend schools where the districts chose SROs over counselors.⁵⁰

Impact of SROs on School Shootings

1
2 There is limited evidence supporting the role of SROs in preventing school shootings.⁵¹ Research
3 on averted school shootings – incidents planned by students and then prevented – suggests that the
4 key is having trusted adults whom other students can inform.⁵² One study found that students are
5 much more likely to report a planned shooting to school staff members; they rarely report this to a
6 member of law enforcement.⁵⁶ There is also limited evidence on whether SROs can stop an active
7 shooter or lower deaths or injuries when a school shooting happens. A recent study found that
8 among all schools that experienced a school shooting between 1999 and 2018, the number of
9 injuries and deaths was about 2.5 times higher in schools that had an SRO.⁵³ However, in at least
10 one instance a school shooter deliberately selected an elementary school with no security personnel
11 instead of the middle school they attended because their middle school had an armed security
12 officer.⁵⁴ Further, one study found in one-quarter of the studied cases with an active shooter, the
13 officer or SRO was able to make it to the scene of the attack within one minute. In three of the
14 attacks (7 percent), it took between one and five minutes for the officer to respond, and for two
15 attacks (5 percent), it took between five and ten minutes.⁵⁵ In sum, further research is needed to
16 understand the role SRO's have in deterring school shooters.

17 18 *Maximizing the Benefits of SRO Programs*

19
20 Although there has been interest in encouraging the expansion of SRO programs to promote school
21 safety, some are concerned about the negative effects SROs could have on the school environment.
22 While research on the efficacy of particular program models or characteristics is limited, the COPS
23 Office, has identified several elements of a successful SRO program.⁵⁶ First, the COPS guide
24 suggests that all schools should develop a comprehensive school safety plan based on their school
25 safety goals and a thorough analysis of the problem(s) the school is facing before determining if it
26 is necessary to employ an SRO.⁵⁹ In some instances, school safety plans might not require the
27 deployment of an SRO. However, if after composing a school safety plan the school decides to use
28 an SRO, there should be clear goals for the program. SROs should engage in problem-solving
29 policing activities that directly relate to school safety goals and address identified needs, and data
30 should be collected to determine whether the program is achieving its goals.

31
32 Second, the COPS guide suggests that schools and the law enforcement agencies that SROs work
33 for should be aware of any pitfalls before agreeing to establish an SRO program.⁵⁹ There may be
34 philosophical differences between school administrators and law enforcement agencies about the
35 role of the SRO. Law enforcement agencies focus on public safety while schools focus on
36 educating students. Establishing an agreed-upon operating protocol or MOU is considered a critical
37 element of an effective school-police partnership. The MOU should clearly state the roles and
38 responsibilities of SROs involved in the program.⁵⁹ However, most schools employing SROs do not
39 enter into a MOU. Further, MOUs are not publicly available on school websites. This means that
40 key stakeholders such as students and families lack easy access to information regarding their
41 rights in relation to interacting with police in schools.⁶⁹

42
43 Third, the COPS guide suggests that selecting officers who are likely to succeed in a school
44 environment—such as officers who can effectively work with students, parents, and school
45 administrators; have an understanding of child development and psychology; and have public
46 speaking and teaching skills—and properly training those officers are important components of a
47 successful SRO program.⁵⁹ While it is possible to recruit officers with some of the skills necessary
48 to be effective SROs, it is also important to provide training so officers can hone skills they already
49 have or develop new skills that can make them more effective. The Police Foundation, for instance,
50 recommends that training for SROs focus on the following:

- child and adolescent development, with an emphasis on the effect of trauma on student behavior, health, and learning,
- subconscious (or implicit) bias that can disproportionately affect youth of color and youth with disabilities or mental health issues,
- crisis intervention for youth,
- alternatives to detention and incarceration, such as peer courts, restorative justice, etc., and
- legal issues like special protections for students with disabilities.⁵⁷

Further, one study that surveyed educators, students, officers, and community members suggests that successful SRO programs can do the following:

- Increase feelings of safety among students, teachers, and administrators,
- Deter aggressive behavior, and empower staff to maintain order and address behavioral issues in a timely fashion,
- Diminish classroom time spent on discipline and behavioral disruptions,
- Improve school safety and reduce school-based crime,
- Increase the likelihood that students report witnessing a crime, and help reduce community-wide criminality, and
- Improve relationships between law enforcement and youth.⁵⁸

EXISTING AMA POLICY

AMA policy H-60.902, “School Resource Officer Qualifications and Training” encourages an evaluation of existing national standards to have qualifications through 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. It also encourages 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.

CONCLUSIONS

Police stationed within K-12 schools, known as SROs, are a common feature of American schools. According to federal data, about half of schools had an SRO on school grounds at least once a week during the 2017-2018 school year.⁵⁹ In the same year, a national survey found that 80 percent of parents supported having police officers in schools, and some states, like Maryland, passed new laws mandating adequate law enforcement at all schools as a result of school shootings.^{60,61} However, since George Floyd’s death in 2020, the U.S. has experienced an intensified debate about the proper role of police in communities, including schools. As a result, school districts, including Chicago and Los Angeles, have significantly cut their budgets for school policing.⁶²

Opponents of SROs often cite specific incidents of police violence against Black students in schools and link SROs to the broader concept of a school-to-prison pipeline, in which students’ early experiences with school discipline and/or police in schools may directly or indirectly influence their lifetime involvement with the criminal justice system.⁶² Critics of SROs fear that having a police officer within a school makes it easier for a student to be formally arrested or referred to juvenile justice for minor acts of misconduct that would otherwise be handled through school discipline.⁶³ This criminalization of school misconduct disproportionately impacts students of color, as evidenced in the existing racial disparities in arrest and incarceration.⁴⁰

Proponents state that school districts often view SROs as the first line of defense against school shootings and other acts of school violence. SROs also aim to act as a specialized form of community policing, a model of policing designed to assign officers to permanent beats, involve students in decision-making, and problem-solve using non-criminal justice techniques such as mentoring and informal sanctions.⁶⁴ Consistent with this logic, research has shown that SROs may improve student attitudes toward the police and improve student and staff perceptions of school safety.²⁶

The current evidence is inconclusive on the effectiveness of de-escalation training for SROs. However, multi-faceted interventions are more likely to be effective, especially in school settings. Examples of evidence-based best practices include training on restorative justice, transformative justice, and trauma-sensitive or trauma-informed schooling.⁶⁵ At the center of each of these approaches is the development of: healthy relationships; processes that support the healing of harm and transformation of conflict; and just and equitable learning environments that confront oppressive structures and systems.⁶⁹

Further, establishing an agreed-upon operating protocol or MOU is considered a critical element of an effective school-police partnership. The MOU should include provisions addressing daily interactions between students and school personnel with school resource officers.⁶⁶ MOUs are widely considered important tools to clarify how SROs should operate in an educational environment.⁶⁷ However, most school districts employing SROs do not have a MOU in place. Research shows that an upfront MOU agreement can result in fewer court referrals, fewer violent offenses, and higher graduation rates.⁶⁸

It is also important to recognize that SROs are part of the school staff at large and shouldn't be considered a separate entity from school counselors, social workers, school psychologists, nurses, and schoolteachers. Their roles should therefore be defined within the team structure of the school. Finally, community-based policing practices ensure that the community plays a role in prioritizing and addressing public safety problems.⁶⁹ SRO programs employing these practices can be used to accomplish two interrelated goals of developing solutions to problems through collaborative problem solving and improving public trust.

RECOMMENDATIONS

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

1. That our AMA amend Policy H-60.902, "School Resource Officer Qualifications and Training" as follows:

1. 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 and adolescent psychology and development, trauma-informed care, restorative justice, peer mediation, conflict resolution, crime awareness, implicit/explicit biases, how to work with children with disabilities and special needs, diversity inclusion, cultural ~~humility~~ competence of the distinct cultural groups represented at schools, de-escalation training, 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. (Modify HOD Policy)

- 1 2. That our AMA encourage: (1) school districts initiating SROs develop and those with
2 existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly
3 outlines processes for officer selection and assessment, defines roles and responsibilities of
4 SROs and their scope relative to school personnel, identifies data to be collected, and
5 establishes a mechanism for program evaluation and oversight; (2) SROs to have access to
6 local public health resources; (3) schools with SRO programs to collect and report data to
7 help evaluate the impact of SROs in schools; and (4) federal and state grant programs
8 which provide funding for SRO programs, require collection and reporting of data to
9 inform policymaking on these programs. (New HOD Policy)
10
11 3. That our AMA acknowledges: (1) SROs are part of the school staff at large and their
12 responsibilities should be defined within the team; and (2) community-based policing
13 practices are essential for a successful SRO program. (New HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 05 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Increasing Public Umbilical Cord Blood Donation in Transplant Centers
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. The first Resolve of Resolution 001-A-22, “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers,” which was referred by the House of Delegates, asked that our American Medical Association (AMA) “encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation.”

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “umbilical cord blood donation,” “public umbilical cord blood donation,” and “umbilical cord blood AND transplantation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations will also be reviewed for relevant information.

DISCUSSION. Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the placenta. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with unrelated donor bone marrow. The predominant disadvantage of umbilical cord blood use is that there is often a low yield of stem cells acquired per unit. In general, UCB can be donated to a private or public bank. A private umbilical cord blood bank is a for-profit company that allows storage of umbilical cord blood for personal use. In contrast, public umbilical cord blood banks offer gratuitous cord blood banking for individuals who meet the donation requirements. This report examines the benefits and limitations of public versus private umbilical cord blood banking.

CONCLUSION. Cord blood banking has been developed to the point that around 800,000 units are being stored in public banks and over 4 million units in private banks worldwide. Although UCB units are not the answer for every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients every year who have no alternative treatment modality. Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One notable barrier is that public UCB banks are required to process, and store collected units within 48 hours of collection. This limits the collection sites to proximally located hospitals. This provides a barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This, coupled with the lack of funding for efforts to improve recruitment and education of expectant parents, leads to insufficient UCB donations and availability for transplant. The recommendations aim to address these barriers to improve and expand the current UCB donations and banking. This report also studies the financial costs of setting up public UCB banks and the long-term financial outlook for maintaining public UCB banks.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 05-A-23

Subject: Increasing Public Umbilical Cord Blood Donation in Transplant Centers

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

INTRODUCTION

The first Resolve of Resolution 001-A-22, “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers,” which was referred by the House of Delegates, asked that our American Medical Association (AMA) “encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation.”

BACKGROUND

Historically, umbilical cord blood (UCB) had no identified value and was disposed of with the placenta. UCB is now known to contain hematopoietic stem cells that have potential life-saving benefits. When used in hematopoietic stem cell transplantation, umbilical cord blood offers several distinct advantages compared with bone marrow or peripheral stem cells. Biologically, a greater degree of human leukocyte antigen (HLA) mismatch is tolerated by the recipient and the incidence of acute graft-versus-host reaction is decreased when umbilical cord blood is used compared with unrelated donor bone marrow.¹ The predominant disadvantage of umbilical cord blood use is that there is often a low yield of stem cells acquired per unit. Only 8–12 percent of umbilical cord blood units have sufficient cell volume for transplant to a person weighing 80 kg (176 lb).² In general, a private UCB bank is a for-profit company that allows storage of UCB for personal use. In contrast, public UCB banks offer gratuitous cord blood banking for individuals who meet the donation requirements. The benefits and limitations of public versus private UCB banking should be reviewed with the patient individually because they serve different purposes.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “umbilical cord blood donation,” “public umbilical cord blood donation,” and “umbilical cord blood AND transplantation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Umbilical Cord Blood

UCB is the blood left over in the umbilical cord and placenta after delivery. Typically, the umbilical cord and placenta are thrown away as medical waste. UCB blood is similar to other sources of blood because it contains red and white blood cells, platelets and plasma. It also contains

a special type of stem cell known as hematopoietic stem cells (HSCs) that can mature or grow into different types of blood cells such as red blood cells, white blood cells, or platelets. Billions of stem cells reside in just a few ounces of cord blood, which is collected painlessly from the umbilical cord after birth. HSCs are used in treating life-threatening malignant and non-malignant diseases of the blood and immune system.³ Researchers have found cord blood is effective in treating up to 80 conditions.⁴ Moreover, clinical studies have proved the pluripotent nature of cord blood cells, highlighting a wide range of possible clinical applications in neonatology, regenerative medicine, and immune modulation.

Umbilical Cord Blood Banking

UCB banking has grown significantly in the past two decades. The option to bank UCB was first made available in the 1990s following the discovery that cord blood is a rich source of stem cells.⁵ UCB banking consists of the collection and storage of the UCB from the placenta and umbilical cord, soon after childbirth.⁶

Three types of UCB banks currently exist: public, private, and hybrid. Public banks store UCB units received altruistically from donors, which are then listed on the Be The Match® Registry (The Registry) and made available for any potential recipient if they are an adequate HLA match.⁷ There is no cost to donate the baby's cord blood to a public bank. Public banks follow strict quality assurance and FDA regulations and will only bank cord blood if it is sterile and contains enough stem cells to use in treatment. However, public cord blood banks do not allow directed storage. In contrast, private banks, also referred to as family banks, store UCB for exclusive future use either by the donor or a matched relative. When a baby's cord blood is stored in a private cord blood bank, the donor pays collection and ongoing storage fees and the UCB is reserved for the donor's use only. As the cord blood is being saved for personal use, private banks are not required to follow the same quality and sterility guidelines as a public bank.⁸ Hybrid banks offer combined public and private UCB storage solutions. In this scenario, either the private bank offers a public donation, or the public bank offers a private storage option.

Recruitment and Donor Education

Public UCB banks are required to process, and store collected units within 48 hours of collection. Therefore, collection tends to occur in geographically proximate hospitals, which is available in a limited number of hospitals in the United States.⁹ This, coupled with the lack of funding for marketing campaigns, means that recruitment and education of expectant parents provided by public UCB banks is minimal, mostly consisting of websites to provide education and guidance to expectant parents who want to donate their baby's cord blood. Most public UCB banks rely on the voluntary participation of physicians, prenatal class instructors, and labor and delivery nurses to encourage expectant parents to donate, provide information about donation, and to collect the cord blood at the time of delivery. Some public UCBs maintain their own staff in collection hospitals to provide information and education about cord blood donation or consent-and-obtain information for the maternal questionnaire. Further, many states have laws requiring obstetricians to inform their patients about cord blood banking.¹⁰ However, most legislation does not specify whether public or private donation should be discussed.

Cord Blood Collection, Processing, and Storage

Families who decide to donate their newborn's cord blood to a public UCB bank must provide a maternal health history and a maternal blood sample for infectious disease screening prior to delivery. Collected cord blood is then packed, stored, and transported, typically in a temperature

monitored environment, to a cell-processing laboratory. While in transit from the collection site to the processing and storage site, time and temperature affect the viability of the cord blood: One study reported a 1-percent drop in cell viability for every 4-hour increase in transit time.¹¹ After collection, but before further testing or processing, many public UCB banks perform an initial assessment of the collected unit to determine its weight and volume. Low weight or volume units are usually discarded or donated to research since they are unlikely to meet minimum cell count requirements for banking and use in transplants.¹²

At any point in the process, a cord blood unit may be identified as unsuitable for storage for any number of reasons, including low volume (i.e., not enough stem cells to use in a transplant), poor viability (i.e., there may be stem cells, but they may not be alive or appropriately functioning), poor results from infectious disease testing, or negative findings from the maternal health questionnaire. Some studies have demonstrated that for every one-hundred births eligible for cord blood donation in which cord blood collection is attempted, approximately forty-five are sent for processing and approximately ten are ultimately stored.¹³

Cord Blood Inventory Management and Withdrawal

Most cord blood stored in public banks in the United States are listed with the National Marrow Donation Program (NMDP), which runs The Registry and serves as a central site for patients seeking HSC transplants of all kinds.¹⁴ Many international banks' cord blood is also available through The Registry. Some public UCB banks may also offer units that do not meet qualifications for being listed on The Registry but may still have value to potential recipients (i.e., they may have lower cell counts, but represent rare HLA types). These are not available through The Registry, but rather are obtained directly through established relationships with UCB banks.

When a patient has a condition that necessitates treatment using an allogeneic HSC transplant, the patient's physician, whether in the United States or abroad, can search existing registries, including The Registry, for a potential match. More than 90 percent of UCB units distributed for transplant in the United States are distributed through The Registry.¹⁵

UMBILICAL CORD BLOOD REGULATION AND GOVERNMENT POLICIES

Federal Policies and Programs

In 1987, the National Bone Marrow Donor Registry (NBMDR) was initiated through a congressionally directed grant from the U.S. Department of the Navy and formally established in 1990 as a responsibility of the U.S. Department of Health and Human Services (HHS), with oversight initially by the National Institutes of Health (National Heart, Lung, and Blood Institute) and, since 1994, by the Health Resources and Services Administration (HRSA).¹⁶ In December 2005, Congress passed the Stem Cell Therapeutic and Research Act (Stem Cell Act 2005).¹⁷ The Stem Cell Act 2005 amended the Public Health Service Act and required the HHS Secretary, through HRSA, to rewrite the provisions that established and maintained the NBMDR. The provisions were rewritten to establish and maintain the C.W. Bill Young Cell Transplantation Program (CWBYCTP), the successor to the NBMDR.

The Stem Cell Acts of 2005, 2010, 2015, 2021 authorized the following:

- The Stem Cell Therapeutic and Research Act of 2005 established the CWBYCTP to replace the NBMDR. In so doing, the Act expanded on the previous requirements of the NBMDR to increase the numbers of marrow donors and cord blood units and continued to

serve patients who need a bone marrow or umbilical cord blood transplant. The CWBYCTP also established an outcomes database to collect data and perform research, as well as offer patient and donor advocacy services, case management services, data collection on transplant outcomes, and educational activities.

- National Cord Blood Inventory (NCBI). The NCBI program contracts with cord blood banks to meet the statutory goal of building a public inventory of at least 150,000 new, high-quality, and genetically diverse UCB units.¹⁸ These UCB units are available for transplantation through the CWBYCTP. The Stem Cell Therapeutic and Research Reauthorization Acts of 2010 also required the U.S. Government Accountability Office to report on efforts to increase cord blood unit collection for the NCBI.
- Advisory Council on Blood Stem Cell Transplantation (ACBSCT). The goal of the ACBSCT is to advise, assist, consult with, and make recommendations to the Secretary of Health and Human Services and the Administrator of HRSA on matters carried out by both CWBYCTP and the NCBI Program.¹⁹

HRSA

HRSA administers the CWBYCTP and manages its various components. HRSA provides funding for the collection of diverse cord blood units for NCBI through contracts to cord blood banks. There are 13 NCBI contractors who bid to provide a certain number of cord blood units of specified types (i.e., racial/ethnic groups).²⁰ Once NCBI-eligible cord blood units are listed on The Registry, public cord blood banks receive a subsidy for cord blood collection, processing, and storage. This subsidy does not cover the entire costs borne by cord blood banks for collection, processing, and storage, but it does help defray some of those costs.

National Marrow Donor Program (NMDP)

The NMDP provides the link between HRSA, UCB banks, and physicians for obtaining stem cells and, specifically, cord blood. The NMDP also acts as the financial intermediary between individual UCB banks and hospitals and provides education for patients and clinicians.²¹

FDA Oversight

The FDA regulates cord blood in a variety of ways, depending on the source, the processing, and the intended use. Cord blood stored in private banks (i.e., for autologous use or use in first- or second-degree relatives) does not need to go through FDA licensure because it is used on the individual from whom it was collected, or on a related individual. In contrast, public UCB banks store UCB units intended for use by a patient unrelated to the donor (i.e., for allogeneic use). Therefore, this use meets the legal definitions of both a “drug” and a “biological product,” which means that public UCB banks must adhere to additional requirements.^{22,23} Public banks are required to comply with good tissue practice regulations, conduct specific donor screening and infectious disease testing, conduct standardized testing on UCB units, and maintain international cellular therapy accreditation. Further, public UCB banks are required to hold licensure from the FDA. The costs and timeline for achieving FDA licensure are reportedly high, with many public UCB banks reporting a 12-to-24-month timeline, initial costs of approximately \$1 million, and ongoing annual costs of more than \$100,000.^{24,25}

It is also important to note that individual UCB units are licensed, not the UCB bank itself. Most public UCB banks in the United States were in operation before the FDA licensure mandate—the FDA issued guidelines for licensure in 2009 and issued the first license in 2011.²⁶ Licensed UCB units meet FDA standards, and unlicensed UCB units are collected and processed

prelicensure or are post-licensure collections that do not meet the requirements specified by the FDA. Public UCB banks that have not achieved FDA licensure will produce only unlicensed UCBs. Finally, UCB units from international banks are also unlicensed. The use of an unlicensed UCB unit must go through the process of an Investigational New Drug (IND) application.²⁷ An IND may be submitted by the UCB bank, the transplant physician, the transplant center, a national or international cord blood registry involved in coordinating the distribution, or another qualified sponsor.²⁷ INDs are granted only for specific uses.²⁶

State Legislation

To date, 28 states have passed some form of cord blood education legislation, which represents 78 percent of the total annual US births.¹⁰ Several other states are in various stages of developing similar legislation to help inform health care professionals and expectant parents of all medically appropriate options for preserving cord blood stem cells.

ADVANTAGES AND DISADVANTAGES OF USING CORD BLOOD STEM CELLS

Advantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells

Physicians and patients balance trade-offs when choosing a suitable stem cell donation for transplant. In some cases, the urgency to perform the transplant makes cord blood stem cells the preferred choice because they are usually available for overnight transport once a suitable match is identified.²⁸ Other factors to consider include time to acquire the donation and quality of the potential stem cell sources, as well as the patient's age and disease. One major advantage to using cord blood stem cells is the fact that they are less differentiated than stem cells from adult sources (i.e., bone marrow or peripheral blood), and therefore are better able to develop into various cell types as they mature. This quality is an asset for transplantation because cord blood stem cells require less-stringent donor-recipient matching than adult stem cells and carry a lower risk for rejection by the recipient's body. Another advantage is that this less-strict matching also implicitly increases access to stem cells as a treatment source for those unable to find suitable matches among other sources.²⁹ This is especially important for racial and ethnic minorities who often have a hard time finding a suitable donor.

Bone marrow and peripheral blood stem cell collection also have disadvantages. Preparations for collection of bone marrow or peripheral blood, such as donor-recipient matching to minimize the chance of rejection, can take several weeks to complete. Collection itself requires the donor to undergo a procedure requiring sedation, typically done in an operating room, or take medication to stimulate stem cell production, both of which can be painful and can require recovery in the hospital.³⁰

Summary of Advantages for Patients

For certain patients, there may be advantages to using donor cord blood stem cells instead of donor peripheral blood or donor marrow stem cells. Some potential advantages include:

Availability. Cord blood stored in a public cord blood bank has been prescreened, tested and frozen and is ready to use. They are usually available for overnight transport once a suitable match is identified.³¹

Human Leukocyte Antigen (HLA) Matching. The outcomes of related and unrelated donor stem cell transplants are strongly affected by the degree of HLA matching between the transplant

recipient and the donor cord blood. HLA matching plays an important role in successful engraftment, severity of graft-versus-host disease (GVHD) and overall survival. A close match between the patient and the cord blood unit can improve a patient's outcome after transplantation.³¹

Graft-Versus-Host Disease. Studies have found that after a cord blood stem cell transplant, fewer patients got GVHD and, among those patients who did develop GVHD, the complication tended to be less severe than it was in patients who had bone marrow or peripheral blood transplants. GVHD is a serious and sometimes fatal complication of allogeneic stem cell transplantation.³¹

Diversity. As a result of extending collection efforts to hospitals where births from diverse ethnic backgrounds are well represented, donated cord blood units have the potential to provide a source of stem cells that reflect racial and ethnic diversity.³¹

Infectious Disease Transmission. Cord blood stem cell transplants carry a lower risk of transmission of blood-borne infectious diseases compared with stem cells from the peripheral blood or marrow of related or unrelated donors.³¹

Disadvantages of Using Cord Blood Stem Cells Over Other Sources for Stem Cells

Although the U.S. government started a federal cord blood program in 2005 to help create a nationwide inventory of high quality and genetically diverse units of cord blood, the proportion of cord blood stem cell transplants relative to transplants using other types of stem cells, such as those from bone marrow, has been falling in recent years.³² The declining demand and increasing costs has led to some of the public UBC banks to struggle to operate financially.

One significant disadvantage to using cord blood stem cells is that the volume of collectible blood is small in comparison to that from an adult donor's bone marrow or peripheral blood. Fewer stem cells means that it takes approximately 10–15 days longer than other sources for the stem cells to establish themselves when introduced in the recipient's bone marrow.³³ This means longer recovery time in the hospital for the recipient. Since bone marrow and peripheral blood can provide more stem cells per donation, the cells usually engraft more quickly in the recipient's bone marrow, so the recipient typically has a shorter recovery period. Further, bone marrow or other peripheral blood stem cells are not required to be licensed.

Summary of Disadvantages for Patients

Clinical Data. Cord blood stem cell transplantation is almost two decades old yet is a relatively new procedure in comparison to transplantation of peripheral blood or marrow stem cells. It is possible that genetic diseases may be present but not apparent at the time of birth and could be transplanted to a patient via donor cord blood stem cells. Procedures to track this possibility require follow-up until the donor infant is months or even years old, but such follow-up has proven difficult. A future approach to address this may be genetic testing for diseases that affect the blood and immune system and for certain metabolic diseases that might be transplantable.³¹

Storage. It is not known how long cord blood can be frozen and stored before it loses its effectiveness. Cord blood samples have been preserved for as long as 10 years and have still been successfully transplanted.³¹

Engraftment. The number of cells required to give a transplant patient the best chance for engraftment and for surviving the transplant is based on his or her weight, age and disease status. A cord blood unit might contain too few stem cells for the recipient's size. Due to the smaller number

1 of stem cells in the cord blood unit, cord blood stem cell transplants engraft more slowly than stem
2 cells from marrow or peripheral blood. Until engraftment occurs, patients are at risk of developing
3 life-threatening infections due to immunosuppression from chemotherapy and/or radiation intended
4 to prepare the recipient for the transplant. Thus, cord blood transplant recipients may be vulnerable
5 to infections for an average of up to one to two months longer than marrow and peripheral blood
6 stem cell recipients.³¹

8 CURRENT DEMAND FOR CORD BLOOD UNITS

10 Overall, stem cell transplants have been on the rise for several years. However, the number of
11 transplants using cord blood has declined over time, from about 12 percent of all HSC transplants
12 to about 8 percent from 2010 to 2015.³⁴ As of 2020, more than three-quarters (77%) of the
13 unrelated transplants and three-quarters (80%) of related transplants were performed using
14 peripheral blood.³⁵ One-seventh (14%) of unrelated transplants used bone marrow and 7% used
15 cord blood units.³⁵ Other factors may contribute to the declining demand for cord blood, such as
16 higher procurement and treatment costs or provider preferences. Over the short term, treatment
17 costs are clearly higher for cord blood transplants relative to other stem cell transplants. This is
18 primarily driven by longer engraftment periods, which translate into longer hospital stays. Research
19 is still needed to determine whether cord blood recipients stay healthier over the long term than
20 recipients of other stem cell types. Further, differences in collection costs are also unclear, as
21 previous studies have tended to ignore the cost of harvesting adult stem cell sources, which can be
22 significant.³⁴

24 Competition among public banks has increased as the net supply of cord blood units has grown.
25 Private banks, in which individuals store cord blood for their own family use, also provide some
26 competition because their units may not be released to the national inventory, keeping that segment
27 of the market off-limits for most patients. In addition, international cord blood banks now supply
28 about 24 percent of units used in the United States, up from 13 percent in 2004.³⁶ The fee that a
29 bank charges a transplant center for a cord blood unit tends to be the same (about \$36,000)
30 regardless of the unit's TNC count or genetic rarity.³⁴ The current market environment for public
31 banks makes it difficult to break even. Costs for public banks include processing, testing, and
32 storage costs; licensure by the U.S. Food and Drug Administration; and overhead costs. The total
33 expenses vary widely, ranging from \$1 million to \$6 million, depending on the size of the
34 operation.³⁷ Further, revenue primarily comes from fees, but also from the NCBI subsidies for
35 registered units, donations, grants, or in-kind donations of services. Banks collect, on average,
36 8,500 units annually but ultimately store only 5 to 40 percent of those collections.³⁸ Among units
37 that have been banked, a low-TNC-count unit has only about a 0.1-percent chance of being used in
38 a given year, as opposed to a 3-percent chance for larger units.³⁷ Because banks collect fees only on
39 units that are used, banks that store low-TNC-count units are more likely to lose money.

41 EQUITY CONSIDERATIONS

43 In the U.S., racial minorities are much less likely to find a suitable blood stem cell donor than
44 White Americans. For example, a Black person has a 29 percent chance of finding a matched donor
45 in the registry, while a white person has a 79 percent chance.³⁹ People who are American Indian
46 and Alaska Native have a 60 percent chance of finding a registry match, Asian and Pacific Islander
47 patients 47 percent, and Hispanic or Latino patients 48 percent.³⁹ People of color make up a small
48 percentage of all donors, making it difficult to find matches for people with cancer who are not
49 white or who are of mixed race and ethnicity.

HSCs from UCB offer the advantage of requiring less stringent HLA-matching criteria (i.e., six loci, rather than 10 as is the case for bone marrow derived HSCs). In addition, since these cells can be cryopreserved, this provides an off-the-shelf solution to patients in urgent need of transplantation. These factors are particularly advantageous for patients from non-Caucasian racial and ethnic groups, especially since this offers access to a worldwide inventory and increased the likelihood of finding a match.^{40,41}

As discussed above, one disadvantage of using UCB is the low yield of HSCs when compared to bone marrow or peripheral blood. Use of a suboptimal HSC cell dose results in delayed recovery, higher graft failure rates and risk of infection.^{45,42} This results in increased hospitalization times and a consequent increase in treatment costs. Double UCB transplantation is often employed to overcome this, causing significant financial burdens to the transplant recipient. The cost factor is particularly pertinent in the context of allogeneic UCB transplantation, when one considers that obtaining a single UCB unit can cost up to \$36,000.⁴³ The costs of double UCB unit transplantation and further manipulations can therefore be prohibitively expensive.

POTENTIAL COST CONSIDERATIONS

Limited information is available about the costs to set up an UCB donation systems in health care settings where a program currently does not exist. As noted above, public UCB banks are required to process, and store collected units within 48 hours of collection. This is essential to maintain the viability of the collected cells. Therefore, this may only be feasible when a public UCB bank is geographically proximate to the hospital. There are significant costs for hospitals to set up public UCB donation centers on site. One example of the potential fiscal cost comes from Connecticut which aimed to establish a public UCB bank between the Department of Public Health (DPH) and the University of Connecticut Health Center (UCHC).⁴⁴ The estimated costs were \$1.9 million, with ongoing annual operating costs of \$2.38 million for the subsequent years.⁴³ These estimates assumed a volume of 1,440 specimens to be collected and stored per year and included costs for personnel, equipment, training, accreditation, reagents, rent, vehicles for transport, freezers, testing, courier services, and computer maintenance.⁴³

Public UCB banks with donation systems in place incur both variable and fixed costs. Variable costs include costs of collection, testing, processing, storing, and distributing the unit.³⁷ Fixed costs include obtaining FDA licensure and overhead costs, such as rent.³⁷ Collection costs include costs of recruiting donors, collection kit supplies, and labor costs. These costs may vary based on the recruitment efforts conducted, as well as whether the bank uses volunteer CBU collectors, or whether it employs its own CBU collectors. There are also significant costs at the processing stage, including separation of the CBU components and HLA-typing to prepare the units for storage.³⁷ Further, the costs banks typically incur to obtain the FDA license are not publicly available. Therefore, average annual overhead costs—which consist of equipment costs, maintenance, rent, utilities, office supplies, and other related expenses—total from \$1.2 million to \$4.5 million, depending on the size and setup of the UCB bank.³⁷

Revenue comes primarily from fees, but also from the NCBI subsidies for registered units, donations, grants, or in-kind donations of services. Banks collect, on average, 8,500 units annually but ultimately store only 5 to 40 percent of those collections.³⁴ Because banks collect fees only on units that are used, banks that store low-TNC-count units are more likely to lose money. Banks have had to get creative with how they structure their businesses to remain viable. Some banks have adopted hybrid models, offering private family banking to cross-subsidize the nonprofit public banking operations under NCBI.³⁴ Some have also improved their financial situation by selling their processing or testing services to private banks.³⁴ Others are part of larger

1 organizations, such as whole blood centers or hospitals, which can offer cheaper transportation and
 2 lab work.³⁴ Despite the current financial limitations, one study calculated that the average annual
 3 value of having a national public bank system range from \$883 million to \$1.7 billion, far
 4 outweighing the aggregate industry operational costs of \$60 million to \$70 million to maintain the
 5 current system.³⁴

6
 7 Other limitations to collecting UCB include the lack of delivery rooms, licensed obstetric nurses,
 8 and the need for more extended opening hours at the local public cord blood bank.⁴⁵ This highlights
 9 the other potential cost considerations that might increase UCB donations at current hospitals with
 10 existing systems set up.

11 12 FEDERATION OF MEDICINE POLICY

13
 14 The American College of Obstetricians and Gynecologists support public UCB donations and state
 15 that public banking is the recommended method of obtaining cord blood. They further state that the
 16 routine use of private cord blood banking is not supported by available data.⁴⁶ In addition, the
 17 importance of contributions from all ethnicities and races to public banks is highlighted. The
 18 American Academy of Pediatrics also supports the use of public cord blood banking, and further
 19 state that it is the preferred method of collecting, processing, and using cord blood cells for use in
 20 transplantation in infants and children with fatal diseases, such as malignancies, blood disorders,
 21 immune deficiencies, and metabolic disorders.⁴⁷

22 23 *Existing AMA Policy*

24
 25 The AMA has policy addressing the use of cord blood for transplantation. Code of Medical Ethics
 26 6.1.5 “Umbilical Cord Blood Banking” states that cord blood is a potential source of stem and
 27 progenitor cells with possible therapeutic applications. Further it states that “physicians who
 28 provide obstetrical care should be prepared to inform pregnant women of the various options
 29 regarding cord blood donation or storage and the potential uses of donated samples.” It also
 30 encourages donation to a public bank. The Code of Medical Ethics 7.3.8 “Research with Stem
 31 Cells” urges physicians who conduct research using stem cells obtained from any source
 32 (established tissue, umbilical cord blood, or embryos) to adhere to institutional review board (IRB)
 33 requirements, ensure that the research is carried out with appropriate oversight and monitoring,
 34 ensure that the research is carried out with appropriate informed consent.

35
 36 AMA Policy H-370.970 “Umbilical Cord Blood Transplantation: The Current Scientific
 37 Understanding” urges physicians to recognize the viability of UCB transplantation as an alternative
 38 to bone marrow transplantation. It also encourages the education of physicians and the public on
 39 UCB donation. Finally, AMA Policy H-370.956 “Increasing Public Umbilical Cord Blood-
 40 Donations in Transplant Centers” encourages the availability of altruistic cord blood donations in
 41 all states and access to public cord banking and the creation of public cord blood banks to support
 42 altruistic cord blood donation.

43 44 CONCLUSION

45
 46 The UCB field has come a long way after 30 years of biomedical and clinical research supported
 47 by public and private cord blood banking. Over 40,000 UCB transplants have been performed, both
 48 in children and in adults, for the treatment of around 80 different medical disorders. Cord blood
 49 banking has been developed to the point that around 800,000 units are being stored in public banks
 50 and over 4 million units in private banks worldwide. Although UCB units are not the answer for
 51 every patient needing a bone marrow transplant, their availability is crucial for hundreds of patients

every year who have no alternative treatment modality. Particularly, cord blood transplants can be critical for pediatric and minority populations. Although sometimes there are alternatives to cord blood, patients often have no appropriate alternative HSC source. In addition, the importance of getting treatment quickly for some patients can make UCB units the best choice compared with other HSC sources that require greater lead time.

Changes in technology or new research findings related to the use of HSCs might increase or decrease the future use of cord blood. Although clinical trials using cord blood typically address rare diseases, research efforts are underway studying new cord blood applications to treat diabetes, traumatic brain injury, stroke, cerebral palsy, and autism. Any new medical applications for cord blood could increase demand for UCB units. There is also research on HSC expansion and related technologies that could increase the utility of small CBUs.

Despite the benefits of UCB donations, multiple barriers exist for cord blood collection. One notable barrier is that public UCB banks are required to process, and store collected units within 48 hours of collection. This limits the collection sites to proximally located hospitals. This provides a barrier for hospitals that lack the appropriate resources or infrastructure to UCB donations. This, coupled with the lack of funding for efforts to improve recruitment and education of expectant parents, leads to insufficient UCB donations and availability for transplant. Most public UCB banks rely on voluntary participation of staff to encourage expectant parents to donate, provide information about donation, and to collect the cord blood at the time of delivery. It should be noted that time of delivery is not optimal for appropriate consent, adding another limitation to umbilical cord blood donation. Further, some public UCBs maintain their own staff in collection hospitals with collection sites to provide information and education about cord blood donation.

RECOMMENDATIONS.

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

1. That our AMA amend Policy H-370.956 “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers” as follows:
 1. Our AMA encourages: (1) the availability of altruistic cord blood donations in all states; ~~and~~ (2) access to public cord banking and the creation of public cord blood banks to support altruistic cord blood donation; (3) all hospitals that provide obstetrics services work to provide access to public (altruistic) umbilical cord blood donation; (4) that when available, to reduce barriers through education of patients about altruistic umbilical cord donation; and (5) that hospitals providing obstetrics services and umbilical cord blood banking facilities work together to create networks to expand access to and increase efficiency of altruistic umbilical cord donations.
 2. Our AMA supports federal funding efforts to increase knowledge sharing across banks and mentoring for centers, physicians, and staff with minimal experience in cord blood collection.
 3. AMA advocates for increased federal and state funding for public UCB banks to create networks to expand access to and increase efficiency of altruistic umbilical cord donations in areas lacking the appropriate infrastructure to effectively collect umbilical cord blood donations.
 4. Our AMA supports efforts to educate physicians about best practices in collecting public umbilical cord blood donations.

- 1
 - 2
 - 3
 - 4
5. Our AMA encourages efforts to increase the diversity of the national inventory of umbilical cord blood through funding that supports banks to add collection sites where more racial and ethnic minority cord blood units can be collected. (Modify Current HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 06 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)
Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or
Corrections
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. AMA Policy D-430.993, “Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections,” as adopted by the House of Delegates (HOD), asked that our American Medical Association (AMA) study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody are provided the autonomy and privacy protections afforded to them by law and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “acute care of patients in custody”, “acute care AND corrections,” and “acute care AND incarceration.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND. The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated nationwide. Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for individuals who are incarcerated. Few states have stand-alone hospitals for incarcerated patients, and in some counties, health departments offer expanded on-site services in their jails, including urgent care facilities. However, when medical care required by an individual who is incarcerated exceeds the capabilities of the correctional facility’s health care services, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients in custody, and face unique medical, legal, and ethical issues.

This report primarily focuses on acute care for patients who interact with law enforcement. It outlines the constitutional rights to health care for incarcerated individuals and the rights for privacy of health information, as well as when that health information may be disclosed. The report also provides recommendations in support of developing standardized best practices and provides best practices should ensure security measures do not interfere with the capacity to provide care for incarcerated individuals.

CONCLUSION. Information on best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. The National Commission on Correctional Health Care remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 06 -A-23

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

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

American Medical Association (AMA) Policy D-430.993, “Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections,” as adopted by the House of Delegates (HOD), asked that our AMA study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the clinicians caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.

BACKGROUND

The U.S. has the highest incarceration rate in the world with 1.9 million people incarcerated nationwide.¹ People of color are incarcerated at higher rates in jails and prisons across the country, which causes disproportionate economic, health, and social harms.²

Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. Federal law mandates basic health care for individuals who are incarcerated. Correctional facilities offer a range of health care services from primary care to hospital-level care. Few states have stand-alone hospitals for incarcerated patients, and in some counties, health departments offer expanded on-site services in their jails, including urgent care facilities. However, when medical care required by an individual who is incarcerated exceeds the capabilities of the correctional facility’s health care services, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of incarcerated patients, are unaware of guidelines for the treatment of patients in custody, and face unique medical, legal, and ethical issues.

This report is specifically focused on acute care of patients in custody. Acute care is defined as a patient who is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery.³ Acute care is generally provided in a hospital by a variety of clinical personnel using technical equipment, pharmaceuticals, and medical supplies to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries.⁴

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “acute care of patients in custody”, “acute care AND corrections,” and “acute care AND incarceration.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Health of incarcerated populations

Compared to the general population, individuals with a history of incarceration have worse mental and physical health; they are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV.^{4,5} Several factors contribute to the prevalence of mortality due to illness and disease in this population. The incarcerated population is largely drawn from the most disadvantaged segments of society, with significant health care needs but limited access to regular care.⁶ As a result, many incarcerated individuals arrive at correctional facilities in poor health with conditions that were previously undiagnosed.

Once incarcerated, the conditions of confinement often have a negative impact on health. Stress associated with institutional life, overcrowding, inadequate access to exercise, improper diet, exposure to infectious diseases, and poor sanitation and ventilation can all contribute to mortality. Further, while incarcerated individuals have a constitutional right to health care, the access to and the quality of the care in correctional facilities are variable.⁷ Insufficient resources play a key role here, especially limited budgets and regulations that require correctional facilities to prioritize treating certain diseases over others. Some facilities tend to focus on those medical conditions that have immediate and broad impact within the facility, such as HIV and tuberculosis, but also have the potential to spill over into the general population. As a result, treatment of other chronic conditions, such as diabetes and heart or kidney problems, may drop in priority.⁸ With few exceptions, nearly all chronic health conditions are more prevalent among incarcerated individuals than the general population. Finally, a major need is increased medical capacity in correctional facilities. Mortality could be reduced if facilities were better equipped to detect acute chronic conditions, such as elevated blood pressure, and respond with adequate care.⁹

Women with a history of incarceration face a greater burden of disease than men with a history of incarceration.^{10,11} For example, female offenders with a history of drug misuse were more likely than their male counterparts to suffer from conditions such as tuberculosis, hepatitis, and high blood pressure.^{21,22} Women with a history of incarceration are also at greater risk for HIV/AIDS, HPV, and other sexually transmitted diseases.^{21,22} Women with a history of incarceration are also more likely to have experienced childhood trauma and physical and sexual abuse than women who are not involved in the criminal justice system, potentially explaining high levels of physical and mental health problems among women who are incarcerated.²²

The number of older adults (ages 50 years and above) in U.S. prisons is growing.^{12,13} Many correctional facilities, however, are not equipped to address the special health needs of these individuals.²³ While incarcerated, some older adults do not receive adequate treatment for their ailments, particularly mental health conditions.^{23,14} For example, one study found that only 18 percent of older adults who are incarcerated were prescribed medication to treat their mental health conditions.²⁵

Constitutional right to correctional health care

Incarcerated individuals oftentimes need medical attention for ailments, injuries, and diseases. However, there can be misconceptions about an incarcerated individuals' medical rights among physicians, medical administrators, prison and jail staff, and law enforcement officials. There have been several landmark rulings regarding health care and incarceration. Two of the major cases are *Estelle v. Gamble*, (1976) and *Farmer v. Brennan*, (1994).^{15,16} In *Estelle*, the U.S. Supreme Court held that failure to provide adequate medical care to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment.⁵ The Supreme Court's decision in *Farmer* held that a prison official's deliberate indifference to a substantial risk to a prisoner violated the Eighth Amendment and resulted in cruel and unusual punishment.⁶ These two cases provide guidance regarding the legal standards for access to health care and deliberate indifference under the Eighth Amendment, but did not define the minimum standards of for medical care in prisons and jails, or a prisoner-patient's rights in medical decision-making.^{5,6} In practice, the standard for establishing an Eighth Amendment violation is very challenging to meet. Federal courts have stated that to constitute deliberate indifference, "treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness."¹⁷

Clinical best practices

Best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. This demonstrates the need to create evidence-based guidelines in the acute care setting for individuals who are incarcerated or who interact with law enforcement, and these guidelines should balance the rights of the patient, the needs of the clinician, and the safety of the institution and law enforcement. Multiple agencies at federal, state, and local levels possess authority over correctional health care. The Federal Bureau of Prisons (BOP) oversees the provision of medical, dental, and mental health services in federal prisons. The vast majority of the incarcerated, however, are held in state prisons and county jails, where standards vary by state and by county. Some facilities are accredited by private organizations, but this accreditation process remains entirely voluntary, leaving the correctional health care system without a uniform set of standards.

National Commission on Correctional Health Care (NCCHC)

Several professional organizations, including the American Medical Association, the American Public Health Association, and later, the National Commission on Correctional Health Care (NCCHC), have since established national standards for correctional health care.²⁷ NCCHC's origins date to the early 1970s, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in 1983 became the NCCHC, an independent, 501(c)(3) nonprofit organization.¹⁸ Forty years later, NCCHC remains dedicated to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources.¹⁸

NCCHC's standards have provided uniquely valuable guidance to help correctional health professionals and administrators improve the health of their incarcerated populations (and the

communities to which they return), increase efficiency of health services delivery, strengthen organizational effectiveness, and reduce the risk of adverse legal judgments.¹⁸ Established by health, mental health, legal, and corrections professions, NCCHC's standards cover the areas of patient care and treatment, governance and administration, personnel and training, safety and disease prevention, special needs and services, and medical-legal issues.¹⁸ The NCCHC is impartial, unbiased, and dedicated only to recognizing and fostering quality in correctional health care. NCCHC is the only accrediting body authorized by the Substance Abuse and Mental Health Services Administration that focuses on corrections.¹⁸

Medicaid Inmate Exclusion Policy

The Medicaid Inmate Exclusion Policy, established in the 1965 Social Security Amendments, almost completely prohibits the use of federal Medicaid funding to care for incarcerated patients. As a result, there is no incentive for correctional facilities that seek accreditation, and voluntary accreditation rates remain low.¹⁹ Facilities often cite staff shortages and monetary and time costs as barriers to accreditation.²⁰ CMS has approved a first-of-its-kind Section 1115 demonstration amendment allowing Medicaid to fund limited services for people incarcerated in California state prisons, jails, and juvenile detention centers up to 90 days before their release.²¹ Under the amendment, the state will seek to increase coverage, continuity of care, and service uptake in carceral settings. Ten other states have applied for similar waivers, and bills in Congress seek to provide a pathway to Medicaid coverage for all incarcerated individuals approaching release.

Health care privacy

The year 1996, marked the enactment of the Health Insurance Portability and Accountability Act (HIPAA) which would later be amended to provide clear guidelines regarding the privacy of a patient's medical records.¹ A main purpose of the Act was the protection of patient health information (PHI) when it was electronically received, handled or shared among health care-related agencies and individuals. HIPAA specifies that certain entities that engaged in those processes are "covered entities."²² In general, a covered entity is defined as an agency that 1) electronically transmits health care information for the purpose of reporting; 2) requests to review PHI in order to secure authorization for the care of patients; and 3) electronically transmits PHI for the benefit of payment and claims from a public or private entity.²³ However, there is confusion regarding the privacy rights of incarcerated patients that needed clarification.

The unique circumstances of incarceration required a separate section under the Act. That section, titled "Correctional institutions and other law enforcement custodial situations," addresses permitted disclosures of PHI for prisoners.²⁴ The language in the section is very broad to permit disclosure in many circumstances. Covered entities may disclose the PHI of inmates without their authorization to correctional institutions or law enforcement officials who have lawful custody of an inmate for the purpose of providing health care to the inmate or for the health and safety of the inmate, other inmates, the officers and employees of the institution and others at the facility, and those responsible for inmate transfer.²⁵ Covered entities may also disclose the PHI of inmates without authorization for law enforcement purposes on the premises of an institution and for the administration and maintenance of the safety, security, and good order of the institution.⁹ These provisions apply only to the release of the PHI of current inmates.⁹

Situations where information may be released include:

- Court-Ordered Subpoenas, Warrants, or Summons: A hospital may release patient information in response to a warrant or subpoena issued or ordered by a court, or a

summons issued by a judicial officer. The hospital may disclose only that information specifically described in the subpoena, warrant, or summons.¹⁷

- Grand Jury Subpoenas: A hospital also may disclose patient information in response to a subpoena issued by a grand jury. Only information specifically described in the subpoena may be disclosed.¹⁷
- Administrative Requests, Subpoenas, or Summons: An administrative request, subpoena, or summons is one that is issued by a federal or state agency or law enforcement official, rather than a court of law.¹⁷
- Disclosures for Identification and Location Purposes: In response to a request by a law enforcement official, a hospital may release certain limited information to the official for purposes of identification and location of a suspect, fugitive, material witness, or missing person.¹⁷
- Victims of a Crime: In response to a request by a law enforcement official, a hospital may disclose information to the official about a patient who may have been the victim of a crime, if the patient agrees to the disclosure. Such agreement may be oral but should be documented.¹⁷
- Custodial Situations: A hospital may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual information about such inmate or individual if the institution or official represents that such information is necessary for the health and safety of the individual.¹⁷

When inmates are released, they have the same privacy rights under HIPAA as all other individuals. Additionally, exclusions exist for safely transporting prisoners to and from medical facilities. Further, HIPAA also includes provisions regarding inmates' ability to exercise protections otherwise granted in the rule. Inmates are excluded from the right to receive notice of possible uses and disclosures of PHI and of their rights and a covered entity's duties with respect to PHI. HIPAA's notice requirement does not apply at all to correctional institutions that qualify as covered entities.²⁶ Inmates have no right to notice regarding PHI created during incarceration, and correctional institutions are not required to send notices to inmates after release.

Medical Decision-Making

All patients, including people who are incarcerated, have the right to make their own health care decisions, including the right to refuse medical care. They also have the right to designate who should make their medical decisions if they become incompetent or incapacitated.²⁷ All patients and their appointed surrogate medical decision-makers, have the right to be properly informed of medical conditions, prognosis, diagnosis, risk and treatment alternatives through the process of informed consent. Wardens, guards, sheriffs, and police officers are not court-appointed legal guardians and therefore cannot make medical decisions on behalf of incarcerated patients.¹²

Incarcerated individuals can appoint a surrogate medical decision-maker through a written advance directive, medical power of attorney, or an oral order.¹² Upon intake into a prison or jail, the incarcerated individual should be asked to list a medical decision-maker. If not asked by officials, the individual can request that such a decision-maker be listed in their medical records.¹² Physicians and medical staff have an ethical and legal duty to adhere to the patient's decisions, including through a surrogate decision-maker. Often, there is a misunderstanding among health care professionals, jail and prison administrators, and law enforcement officials that health care decisions can be made by wardens, sheriffs, guards, or police officers if an incarcerated patient is incapacitated. Under medical ethics and most state laws, those officials do not have medical decision-making authority for incapacitated prisoners.

1 An area of frequent confusion in medical decision-making for people who are incarcerated involves
 2 a legally eligible or appointed surrogate decision-maker that is neither known and/or available.²⁸
 3 This can be problematic when people are experiencing housing insecurity or are under the
 4 influence of drugs or alcohol when arrested. In cases when doctors and corrections officials do not
 5 know a legally eligible or appointed medical decision-maker, states have codified the legal
 6 hierarchy of medical-decision making through various statutes.¹³ Many states recognize that
 7 medical decisions for an incapacitated patient, without an appointed medical surrogate or proxy,
 8 should be made on a familial basis. If a legal appointed medical decision-maker cannot be located,
 9 then a court must appoint one on behalf of the patient through the legal guardianship process.

10
 11 In the event of a medical emergency, any contact, advance directive or guardianship information
 12 that corrections or law enforcement officials have for a prisoner-patient should be given to medical
 13 staff at the prison or jail infirmary or local hospital.²⁹ Prison and law enforcement officials must
 14 refrain from making medical treatment decisions on behalf of incarcerated patients, and doctors
 15 must refrain from following treatment decisions made by such officials. It may even be necessary
 16 for the hospital to use various means to attempt to determine the medical decision-maker if no
 17 information is available from the patient, such as requesting their prison or jail medical records or
 18 intake information.¹⁴ Regardless, physicians cannot delegate to prison and law enforcement
 19 officials a prisoner-patient's medical decision-making authority. Those officials can make
 20 recommendations regarding the safety of patients or physicians either in the prison or jail infirmary
 21 or local hospital, but such recommendations should not interfere with the patient's treatment
 22 protocol.¹⁴ If information is not available through an advance directive, appointed decision-making
 23 surrogate or lineage, the healthcare staff will have to default to the best medical interest standard
 24 for the prisoner-patient's care.

25 *Forcible Medical Procedures*

26
 27
 28 Several alarming cases of forced medical procedures performed on prisoners, in the form of
 29 surgery or body cavity searches, have been reported. In *Sanchez v. Pereira-Costillo*, the First
 30 Circuit Court of Appeals agreed with the plaintiff, that a surgical procedure conducted by doctors
 31 at the direction of corrections officials in Puerto Rico had violated his rights.³⁰ Prison staff thought
 32 that the plaintiff had a cell phone hidden in his rectum. Despite X-rays and bowel movements
 33 indicating there was no phone, staff at the Río Piedras Medical Center performed exploratory
 34 surgery at the request of prison officials. The Court of Appeals noted in its opinion that "the
 35 exploratory surgery of his abdomen" violated the plaintiff's rights under the Fourth Amendment.¹⁵
 36 Furthermore, one issue that affects prisoners with respect to forced treatment, involuntary body
 37 cavity searches and medical decision-making is a doctor's dual loyalties, which can be problematic
 38 in correctional health care.³¹ Physicians may work as employees or contractors at prisons and jails,
 39 and sometimes have conflicts of interest between their patients and employer.

40 *Shackling*

41
 42
 43 Shackling refers to a form of restraint using a physical or mechanical device to control the
 44 movement of an incarcerated individuals' body or limbs.³² It has been highlighted those conditions
 45 in which the limitations are imposed by shackling, such as the increased risk of thrombosis from
 46 reduced mobility, or related to the shackle itself could predispose patients to unnecessary harm.^{31,33}
 47 In addition to physical harm or discomfort, one study demonstrated that patient shackling was
 48 negatively associated with health care professional empathy toward patients who were
 49 incarcerated.³⁴ In the United States, particular attention has been focused on the shackling of
 50 incarcerated pregnant persons. The FIRST STEP Act of 2018 banned shackling of pregnant women
 51 in federal custody from the date on which pregnancy is confirmed until their postpartum

recovery.³⁵ The majority of women, however, are incarcerated in state prisons.³⁶ Currently, 22 states and the District of Columbia prohibit or limit shackling of pregnant women. States vary in legislation, with some banning shackles during transport, childbirth, and postpartum, whereas other states ban shackles only during labor and birth.³⁷

Shackling policies for patients in custody should be differentiated from hospital restraint policies for patients who are agitated or combative. Since shackles are often placed for nonmedical reasons, the treating clinician should determine whether appropriate care can be delivered with shackles in place.³⁸ Custody officials are then responsible for determining an alternative manner to safely secure, or not secure, a patient who is incarcerated that allows for standards of medical care to be met.

Discharge Prescribing

Physicians may also be concerned that medications prescribed on discharge will be misused by patients in the correctional system, causing physicians to restrict or reconsider certain classes of medication in the hospital or on discharge.³⁹ Commonly diverted medications in the correctional setting include opioids, benzodiazepines, stimulants, antipsychotics, and γ -aminobutyric acid agonists.⁴⁰ A study of incarcerated individuals found that 51.5 percent of participants reported using illicit substances during incarceration, most commonly alcohol (35 percent) and cannabis (37.9 percent), followed by narcotics (14.6 percent).⁴¹ A variety of psychotropic medications are also misused in the correctional setting, although prescription medications lag behind more common substances, such as alcohol and cannabis. Another study examining opioid agonist therapies at a large jail, found that the medications for only 6 percent of patients were discontinued during a month because of diversion concerns.⁴² Further, there is no evidence that rates of diversion are increased among patients who are incarcerated relative to those in a community setting, and the monitored correctional environment may provide a safer setting for medications with diversion risk.⁴³

EXISTING AMA POLICY

AMA policy D-430.997 “Support for Health Care Services to Incarcerated Persons” supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; encourages all correctional systems to support NCCHC accreditation; and encourages 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. This policy also calls on the AMA to work with an accrediting organization, such as 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.

AMA policy H-315.975 “Police, Payer, and Government Access to Patient Health Information” advocates for protection of PHI but notably advocates “with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.”

Further, AMA policy H-430.980 “Compassionate Release for Incarcerated Patients” supports policies that facilitate compassionate release for incarcerated patients based on serious medical

conditions and advanced age. The Board of Trustees previously presented a report to the House of Delegates on compassionate release for incarcerated individuals.⁴⁴

CONCLUSION

The U.S. has the highest incarceration rate in the world. Compared to the general population, individuals with a history of incarceration are in worse mental and physical health. Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. The U.S. Supreme Court has indicated that failure to provide adequate medical care to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment. However, in practice, federal courts have stated that to constitute "deliberate indifference," treatment must be so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.

The principles of privacy and confidentiality apply to all patients, including those who are incarcerated. HIPAA also equally applies to incarcerated individuals unless PHI disclosure is necessary for the provision of health care or safety of the patient, or other individuals in the facility.⁸ Hospital security policies may contravene this principle of confidentiality. The policy at many institutions requires that officers be permitted to always remain with a patient in custody, and although it is suggested that conversations be conducted out of hearing range, the officers must be allowed to remain within direct sight of the patient.⁴⁵

Information on best practices and management of medical conditions among hospitalized patients who are incarcerated or interact with law enforcement is limited and primarily focuses on the care of pregnant individuals. NCCHC remains the only national organization dedicated solely to improving correctional health care quality. This is done by establishing rigorous standards for health services in correctional facilities, operating a voluntary accreditation program for institutions that meet those standards, offering certification for correctional health professionals, conducting educational conferences and webinars, and producing industry-specific publications and other resources. AMA policy supports NCCHC standards. However, there is a need to incentivize correctional facilities to pursue accreditation.

RECOMMENDATIONS

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

1. That our AMA amend policy D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections" to read as follows:

~~1. Our AMA will study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision making capacity), their surrogates, and the clinicians caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.~~

1. Our AMA supports the development of: (1) best practices for acute care of patients in the custody of law enforcement or corrections, (2) clearly defined and consistently

1 implemented processes between health care professionals and law enforcement that (a)
2 can best protect patient confidentiality, privacy, and dignity while meeting the needs of
3 patients, health professionals, and law enforcement and (b) ensures security measures
4 do not interfere with the capacity to provide medical, mental health, pregnancy, end of
5 life/palliative, and substance use care, especially in emergency situations, and (3) a
6 hospital or health system-based health care professional and law enforcement liaison
7 team, that includes, but is not limited to, clinicians, members of the ethics committee,
8 hospital security, and legal services to serve as an immediate resource when questions
9 or conflicts arise. (Amend Current HOD Policy)

- 10
11 2. That our AMA affirms that: (1) the adoption of best practices in the acute care of patients
12 in the custody of law enforcement or corrections is an important effort in achieving overall
13 health equity for the U.S. as a whole, and (2) it is the responsibility of the medical staff to
14 ensure quality and safe delivery of care for incarcerated patients. (New HOD Policy)
15
16 3. That our AMA reaffirm Policy D-430.997 “Support for Health Care Services to
17 Incarcerated Persons” and Policy H-420.957 “Shackling of Pregnant Women in Labor.”
18 (Reaffirm HOD Policy)

Fiscal Note: less than \$1,000

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REPORT 07 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-23)

Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery (Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 407-A-22, referred by the House of Delegates, asked our American Medical Association to study the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and study other validated, easily obtained alternatives to BMI for estimating risk of weight-related disease, and report its findings and report its findings to the AMA House of Delegates by the 2023 Annual Meeting. While this report was in development, the HOD also referred Resolution 937-I-22, “Indications for Metabolic and Bariatric Surgery” for consideration within this report. That resolution asked that our AMA acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “Body Mass Index (BMI),” “alternatives to BMI,” “BMI and Eating Disorders,” “Bariatric Surgery,” and “BMI AND culturally diverse.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. Body mass index (BMI) is easy to measure, is inexpensive, has standardized cutoff points for overweight and obesity, and is strongly correlated with body fat levels as measured by the most accurate methods. BMI is not a perfect measure, because it does not directly assess body fat. The current BMI classification system is also misleading regarding the effects of body fat mass on mortality rates. Numerous comorbidities, lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors, duration of time one spends in certain BMI categories, and the expected accumulation of fat with aging are likely to significantly affect interpretation of BMI data, particularly in regard to morbidity and mortality rates. Other methods to measure body fat are not always readily available, and they are either expensive or need to be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods. Further, the use of BMI is problematic when used to diagnose and treat individuals with eating disorders, because it does not capture the full range of abnormal eating disorders.

CONCLUSION. This report evaluates the problematic history of BMI and explores other alternatives to BMI. It outlines the harms and benefits to using BMI and points out that BMI is inaccurate in measuring body fat in multiple groups because it does not account for the heterogeneity across race/ethnic groups, sexes, and age-span. The recommendations recognize the issues with the use of BMI clinically, and highlights the need to use other methods. This report also acknowledges that AMA did not participate in the development of the “Indications for Metabolic and Bariatric Surgery” guidelines and therefore cannot endorse these guidelines.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 07-A-23

Subject: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 Resolution 407-A-22, referred by the House of Delegates (HOD), asked that our American Medical
2 Association (AMA):

3
4 recognize the significant limitations and potential harms associated with the widespread use of
5 body mass index (BMI) in clinical settings and supports its use only in a limited screening
6 capacity when used in conjunction with other more valid measures of health and wellness; and

7
8 support the use of validated, easily obtained alternatives to BMI (such as relative fat mass,
9 body adiposity index, and the body volume index) for estimating risk of weight-related disease;
10 and

11
12 amend policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and Waist
13 Circumference in the Diagnosis and Management of Adult Overweight and Obesity,” by
14 addition and deletion to read as follows:

15
16 The Clinical Utility of Measuring Body Mass Index Weight, Adiposity, and Waist
17 Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866
18 Our AMA supports:

19 (1) greater emphasis in physician educational programs on the risk differences ~~among ethnic~~
20 ~~and age within and between demographic groups~~ at varying weights and levels of adiposity
21 ~~BMI~~ and the importance of monitoring waist circumference in all individuals ~~with BMIs below~~
22 ~~35 kg/m²~~;

23 (2) additional research on the efficacy of screening for overweight and obesity, using different
24 indicators, in improving various clinical outcomes across populations, including morbidity,
25 mortality, mental health, and prevention of further weight gain; and

26 (3) more research on the efficacy of screening and interventions by physicians to promote
27 healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their
28 patients to improve health and minimize disease risks. (Modify Current HOD Policy); and
29 amend policy H-150.965, by addition to read as follows in order to support increased
30 recognition of disordered eating behaviors in minority populations and culturally appropriate
31 interventions:

32
33 H-150.965 – Eating Disorders

34 The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to
35 one’s physical and mental health as obesity; (2) asks its members to help their patients avoid

obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)

While this report was in development, the HOD also referred Resolution 937-I-22, “Indications for Metabolic and Bariatric Surgery” for consideration within this report. That resolution asked that our AMA:

acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery; immediately call for full acceptance of these guidelines by insurance providers, hospital systems, policy makers, and government healthcare delivery entities; and work with all interested parties to lobby the legislative and executive branches of government to affect public health insurance coverage to ensure alignment with these new guidelines.

BACKGROUND

Body mass index (BMI) is the ratio of weight to height, calculated as weight (kg)/height (m²), or weight (lb)/height (in²) multiplied by 703.¹ BMI is easy to measure, is inexpensive, has standardized cutoff points for overweight and obesity, and is strongly correlated with body fat levels as measured by the most accurate methods. However, BMI is an indirect and imperfect measurement as it does not distinguish between body fat and lean body mass. It is not as accurate of a predictor of body fat in the elderly and at the same BMI women on average have more body fat than men and Asians have more body fat than whites.¹ Further, when combined with measuring waist circumference, patients may be screened for possible health risks that come with being overweight and having obesity. If most of the fat is around the waist rather than at the hips, an individual is at a higher risk for heart disease and type 2 diabetes.¹ This risk goes up with a waist size that is greater than 35 inches for women or greater than 40 inches for men.

BMI is used because it is an inexpensive and easy tool. Research has shown that BMI is strongly correlated with the gold-standard method for measuring body fat known as dual-energy x-ray absorptiometry (DXA), and it is an easy way for clinicians to screen who might be at greater risk of health problems due to their weight.² Other methods to measure body fat include skinfold thickness measurements (with calipers), underwater weighing, bioelectrical impedance, and isotope dilution.² However, these methods are not always readily available, and they are either expensive or need to be conducted by highly trained personnel. Furthermore, many of these methods can be difficult to standardize across observers or machines, complicating comparisons across studies and time periods.

BMI is just one of several considerations to help determine a more specific and individualized course of action for patients. Some researchers are advocating for a new kind of classification system based on the concept of Adiposity-Based Chronic Disease (ABCD) — focusing more on the health issues associated with obesity rather than body size alone.³ The diagnostic term reflects both the pathophysiology and clinical impact of obesity as a chronic disease. The proposed coding system has four domains: pathophysiology, body mass index (BMI) classification, complications,

and complication severity; and incorporates disease staging, specific complications that impact health, the basis for clinical intervention, individualized treatment goals and a personalized medicine approach.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “Body Mass Index (BMI),” “alternatives to BMI,” “BMI and Eating Disorders,” “Bariatric Surgery,” and “BMI AND culturally diverse.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

Prevalence of obesity in the U.S.

In 2021, the CDC Adult Obesity Prevalence Map shows that obesity remains high. Nineteen states and two territories currently have an obesity prevalence at or above 35 percent, more than doubling from 2018.⁴ Adults with obesity are at increased risk for many other serious health conditions such as heart disease, stroke, type 2 diabetes, some cancers, and poorer mental health. Obesity also disproportionately impacts some racial and ethnic minority groups.⁴ Non-Hispanic Black adults had the highest prevalence of self-reported obesity (41.7 percent), followed by non-Hispanic American Indian or Alaska Native adults (38.4 percent), Hispanic adults (36.1 percent), non-Hispanic White adults (31.0 percent), and non-Hispanic Asian adults (11.7 percent).⁴

Childhood obesity is a serious problem in the United States that puts children and adolescents at risk for poor health outcomes. From 2017-2020, the prevalence of obesity was 19.7 percent and affected about 14.7 million children and adolescents.⁵ Obesity prevalence was 12.7 percent among 2- to 5-year-olds, 20.7 percent among 6- to 11-year-olds, and 22.2 percent among 12- to 19-year-olds. Obesity prevalence was 26.2 percent among Hispanic children, 24.8 percent among non-Hispanic Black children, 16.6 percent among non-Hispanic White children, and 9.0 percent among non-Hispanic Asian children.⁵ Obesity-related conditions include high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.⁵

History of measures to calculate body weight (Body Build Index)

The concept of body fat as a major population-based medical issue gained popularity only shortly before 1900. Life insurance data accumulated at that time and subsequently indicated that body weight, adjusted for height (Wt/Ht), was an independent determinant of life expectancy, and in 1910, the effects of being overweight were noted to be greater for younger people than for the elderly.⁶ The Metropolitan Life Insurance Company in 1959 published tables of average body weights for heights (Wt/Ht), also known as body build, by gender and at different ages.⁷ This was based on data from 1935 to 1953 from more than 4 million adults, mostly men, insured by 26 different insurance companies. The risk for development of certain diseases as well as mortality data related to Wt/Ht differences also were analyzed and reported in the 1960 Statistical Bulletin of the Metropolitan Life Insurance Co.⁸

The Wt/Ht tables were used for many years as a reference for population-based studies. If a person’s Wt/Ht was 20 percent above or below the mean for that height category, they were considered to be overweight or underweight, respectively.¹⁴ The insurance data also indicated the

ratios of weights for heights at which mortality was lowest in adults. The latter was referred to as the “ideal” or later the “desirable” weight. From 1959 to 1983, the weight/height representing the lowest mortality had increased.^{9,10} However, a “desirable body” weight for height was invariably lower than the average weight for height in the insured population.^{15,16}

Challenges with the wt/ht (body build) index

Early on it was recognized that taller people had a lower death rate than shorter people with the same Wt/Ht ratio.¹¹ It also was recognized that a person’s height in general and leg length could affect the calculated body mass adjusted for height. A person’s bone mass could also affect the interpretation of this ratio. In general, it reflected whether one was narrowly or broadly built. Thus, efforts were made to eliminate lower limb length and frame size as variables.¹³ The strategy was to develop representations of body build, that is, charts of weight/height that were independent of these variables. The overall goal was to have the same distribution of Wt/Ht at each level of height.

Although not stated, the implicit goal in developing these tables was to define a person’s fat mass as a proportion of their total mass, irrespective of their height or frame size.¹² Efforts were made to adjust for frame size (nonfat mass) by categorizing people as those with a small, medium, or large frame. Estimation of frame size was attempted using several measurements including shoulder width, elbow width, knee width, ankle width, and so on.¹³ None of these were widely adopted. Further, frame size based on elbow width was included in the Metropolitan Life weight/height tables, even though it was never validated.¹³

Adoption of the BMI as an index of obesity

In 1972, the validity of Metropolitan Life Insurance published data was criticized.¹⁴ Critics supported the use of the better documented weight for height data, which then popularized what is known as the Quetelet Index. The Quetelet Index was later known as an individual’s body mass index (BMI). However, it was noted that even BMI rather poorly represents a person’s percent of body fat.²⁰ Despite all the criticisms, the Metropolitan Life Tables criteria for defining obesity were widely used in the United States until the early 1990s.^{15,16} At about that time, the World Health Organization (WHO) classification of body weight for height, based on the BMI, was published, and later it was widely adopted.^{17,18} The distribution of BMIs in adult American men and women was determined in 1923 in 1026 individuals.¹⁹ The median BMI was 24, but the mean BMI was 25. The distribution curve indicated a skewing toward an increase in BMI, and this trend has continued.²⁴

WHO and the categorization of BMIs into quartiles

In 1993, the WHO assembled an Expert Consultation Group with a charge of developing uniform categories of the BMI. The results were published as a technical report in 1995.²⁰ Four categories were established: underweight, normal, overweight, and obese. An individual would be considered underweight if their BMI was in the range of 15 to 19.9, normal weight if the BMI was 20 to 24.9, overweight if the BMI was 25 to 29.9, and obese if it was 30 to 35 or greater.²⁶

At the time that the WHO classification was published, the National Institutes of Health (NIH) in the United States classified people with a BMI of 27.8 (men) and 27.3 (women) or greater as being overweight. If they were below this BMI, they were considered to be “normal.” This was based on an 85 percent cutoff point of people examined in the National Health and Nutrition Examination Study (NHANES) II.²¹ Subsequently, in 1998, the cutoff point between normal and overweight was reduced to a BMI of 25 to bring it into line with the 4 categories in the WHO guidelines.²² This

then changed the categorization of millions of Americans from being “normal weight” to being “overweight.”

In Western population-based studies, the mean or median BMI was about 24 to 27.^{23,24} Therefore, the consequence of adopting the WHO classification resulted in approximately 50 percent or more of the general adult population being classified as overweight and obese. Indeed, the term “overweight” or particularly “preobesity” is prejudicial since people in this category were a major part of the expected normal distribution of BMI in the general population.

Advantages of BMI

A significant advantage of BMI is the availability of extensive national reference data and its established relationships with levels of body fatness, morbidity, and mortality in adults.²⁶ BMI is particularly useful in monitoring the treatment of obesity, with a weight change of about 3.5 kg needed to produce a unit change in BMI. In adults, BMI levels above 25 are associated with an increased risk of morbidity and mortality, with BMI levels of 30 and greater indicating obesity.²⁵ In children, BMI is not a straightforward index because of growth. However, high BMI percentile levels based on Centers for Disease Control and Prevention (CDC) BMI growth charts and changes in parameters of BMI curves in children are linked to significant levels of risk for adult obesity at corresponding high percentile levels.²⁶ Further, BMI is readily available, inexpensive, can be administered easily, and is understood easily by patients.²⁷ BMI can also be used as an initial screening tool to identify those at an elevated health risk because of excess body weight and poor distribution of fat mass.

Disadvantages of BMI

BMI as a determinant of body fat mass. BMI does not differentiate between body lean mass and body fat mass; a person can have a high BMI but still have a very low-fat mass and vice versa.^{28,29} From an anatomical and metabolic perspective, it has been proposed that the term obesity should refer to an excessive accumulation of body fat (triacylglycerols). The accuracy of the BMI as a determinant of body fat mass has been repeatedly questioned because it has limitations in this regard.^{30,31} Gender, age, ethnicity, and leg length are important variables not considered by BMI.^{32,33} It should also be noted that in population-based studies women generally have a BMI that is lower than that in men, even though their fat mass relative to their body build or BMI is considerably greater.

The relatively poor correlation between percent of body fat mass and BMI has been shown more recently in the NHANES III database in which bioelectrical impedance was used to estimate the fat component of body composition.³⁹ In subjects with a BMI of 25 kg/m², the percent of body fat in men varied between 14 percent and 35 percent, and in women it varied between 26 percent and 43 percent. Therefore, using the NIH criteria based on percent of body fat to define obesity, subjects with a BMI of 25, a group that would be considered “normal,” were associated with a body fat mass that varied between “low normal” to “obese.”

In addition, a recent study in individuals with or without diabetes in which the loss of lean body mass with aging was reported, the mean BMI in those without diabetes was 26.8. In those with diabetes, the BMI was 29.1. However, the percent of lean body mass was the same and therefore the increased BMI in those with diabetes was not due only to an excessive accumulation of fat.³⁴ Overall, although the correlation between the BMI and body fatness is strong, two people might have the same BMI, but the level of body fatness may differ.³⁵ Some examples of this include:

- Women tend to have more body fat than men,

- The amount of body fat may be higher or lower depending on the racial/ethnic group,³⁶
- Older people, on average, tend to have more body fat than younger adults, and
- Athletes have less body fat than do non-athletes.

BMI does not account for body fat location. BMI does not capture body fat location information, which is an important variable in assessing the metabolic as well as mortality consequences of excessive fat accumulation. This was first recognized in France by Dr Jon Vague in the 1940-1950s.³⁷ He noted that accumulation of fat in the upper part of the body versus the lower part of the body was associated with an increased risk for coronary heart disease, diabetes, and also gallstones and gout. Men tend to accumulate fat in the abdominal (upper body) area, whereas women tend to accumulate it in the peripelvic (gluteal) area and the thighs. A substitute for this information has been to determine the abdominal circumference or an abdominal/hip circumference ratio. Subsequent data indicate that the risk for development of diabetes as well as coronary heart disease, is more strongly related to the accumulation of upper body fat than lower body fat in both sexes.³⁸

More specifically, both visceral fat accumulation and an expanded girth have been associated with development of insulin resistance, diabetes, and risk for coronary heart disease and hypertension.³⁹ Accumulation of fat in the abdominal area appears to correlate best with triacylglycerols accumulating in the liver and skeletal muscle. Further, the relatively small accumulation of fat in these organs would not be detectible by BMI determinations, and they do not correlate with total body fat mass.⁴⁰

BMI does not account for the life cycle and location of accumulated fat caused by hormones. Girls tend to accumulate relatively large amounts of fat during and after puberty, particularly in the peripelvic and thigh region; boys do not. During and after puberty, boys accumulate a relatively large amount of lean mass (bone and muscle) but not fat mass. In both sexes, these changes are reflected in an increased BMI. With aging, both sexes tend to develop fat in the upper part of the body.⁴¹ The reason for these changes in amount and distribution is not completely understood. Generally, it is considered to be caused by hormonal changes. Further, a study noted BMI cutoffs fail to capture most postmenopausal women whose actual body fat percentage would classify them as obese.⁴² As women age, they tend to lose bone and muscle mass, which are heavier than fat. So even if a 65-year-old woman weighs the same as she did at 25 years of age, fat accounts for a larger share of her weight. The study suggested that to improve the sensitivity of BMI in identifying postmenopausal women at risk of obesity-related diseases, the obesity cutoff might need to be set to 24.9, which is currently the top of the normal BMI range for the general adult population.⁴²

BMI as a predictor of morbidity and mortality. The BMI classification system currently is being widely used in population-based studies to assess the risk for mortality in the different categories of BMI. Even when some comorbidities are considered, the correlation of mortality rates with BMI often does not take into consideration such factors as family history of diabetes, hypertension, coronary heart disease, metabolic syndrome, dyslipidemias, familial longevity or the family prevalence of carcinomas, and other genetic factors. For example, it has been reported that more than 50 percent of susceptibility to coronary artery disease is accounted for by genetic variants.⁴³

Frequently, when correlations are made, they also do not take into consideration a past as well as a current history of smoking, excessive alcohol use, serious and persistent mental illness or the duration of obesity, when in the life cycle it appeared, and whether the body weight is relatively stable or rapidly progressive. In most population-based studies, only the initial weight and/or BMI are given, even though weight as well as fat stores are known to increase and height to decrease with aging. In addition, the rate of weight gain varies among individuals, as does the loss of muscle

mass.⁴⁴ Muscle mass has been correlated negatively with insulin resistance and prediabetes.⁴⁵ Lastly, population-based studies do not take into consideration the present and past history of a person's occupation, medication-induced obesity, and how comorbidities are being treated.

BMI does not appropriately represent racial and ethnic minorities. The rise in obesity prevalence rates has disproportionately affected U.S. minority populations. For example, one longitudinal study of healthy women found that at the same BMI, Asians had more than double the risk of developing type 2 diabetes than whites; Hispanics and blacks also had higher risks of diabetes than whites, but to a lesser degree.⁴⁶ Increases in weight over time were more harmful in Asians than in the other ethnic groups: For every 11 pounds Asians gained during adulthood, they had an 84 percent increase in their risk of type 2 diabetes; Hispanics, blacks, and whites who gained weight also had higher diabetes risks, but again, to a much lesser degree than Asians.⁴⁶ Several other studies have found that at the same BMI, Asians have higher risks of hypertension and cardiovascular disease than their white European counterparts, and a higher risk of dying early from cardiovascular disease or any cause.^{47,48}

Researchers are still assessing why Asians have higher weight-related disease risks at lower BMIs. One possible explanation is body fat. When compared to white Europeans of the same BMI, Asians have 3 to 5 percent higher total body fat.⁴⁹ South Asians, in particular, have especially high levels of body fat and are more prone to developing abdominal obesity, which may account for their very high risk of type 2 diabetes and cardiovascular disease.⁵⁰ In contrast, some studies have found that blacks have lower body fat and higher lean muscle mass than whites at the same BMI, and therefore, at the same BMI, may be at lower risk of obesity-related diseases.⁵¹ While genetic differences may be at the root of these different body fat patterns in Asians and other ethnic groups, environmental factors seem to be a much stronger force. For example, research suggests that under-nutrition during fetal life, such as during the Chinese famine of 1954 to 1964, raises the risk of diabetes in adulthood, especially when individuals live in nutritionally rich environments later in life.⁵²

BMI AND EATING DISORDERS

Eating disorders are behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotion. Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorders, pica and rumination disorder. Eating disorders affect up to 5 percent of the population, and most often develop in adolescence and young adulthood.⁵³ Evidence suggests that genes and heritability also play a part in why some people are at higher risk for an eating disorder.⁵³

Anorexia nervosa is an eating disorder characterized by self-starvation and weight loss resulting in low weight for height and age.⁵³ BMI is used to diagnose an individual with anorexia nervosa and is determined by an individual having a BMI of 18.5 or less.⁵³ Although BMI is used to diagnose anorexia nervosa, BMI does not accurately capture individuals with bulimia nervosa. Individuals with bulimia nervosa can be slightly underweight, normal weight, overweight or even obese.⁵³ Further, BMI is inaccurate in capturing individuals with other specified feeding and eating disorders. These include eating disorders or disturbances of eating behavior that cause distress and impair family, social or work function but do not fit the other categories. In some cases, this is because the frequency of the behavior does not meet the diagnostic threshold (i.e., the frequency of binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia nervosa are not met.⁵³ An example of another specified feeding and eating disorder is "atypical anorexia nervosa". This category includes individuals who may have lost a lot of weight and whose

behaviors and preoccupation with weight or shape concerns and fear of fatness is consistent with anorexia nervosa, but who are not yet considered underweight based on their BMI because their baseline weight was above average.⁵³ Therefore, utilizing BMI can lead to substandard treatment, typically due to the use of BMI by insurance companies to cover inpatient treatment.⁵⁴ Further, as mentioned above, BMI is an inaccurate measure of obesity especially in children and adolescents and can therefore hinder access to eating disorder treatments.⁴¹

OTHER DIAGNOSTIC MEASURES FOR DIAGNOSING OBESITY

Abdominal Circumference

Obesity is commonly associated with increased amounts of intra-abdominal fat. A centralized fat pattern is associated with the deposition of both intra-abdominal and subcutaneous abdominal adipose tissue.⁵⁵ It should be noted that abdominal circumference is an imperfect indicator of intra-abdominal adipose tissue, as it also includes subcutaneous fat deposition, as well as visceral adipose tissue. This does not preclude its usefulness, as it is associated with specific health risks.⁵⁶ Persons in the upper percentiles for abdominal circumference are considered to have obesity and at increased risk for morbidity, specifically type 2 diabetes and the metabolic syndrome, and mortality.⁵⁷ The ratio of abdominal circumference (often referred to incorrectly as “waist” circumference) to hip circumference is a rudimentary index for describing adipose tissue distribution or fat patterning.⁵⁸ Abdomen-to-hip ratios greater than 0.85 represent a centralized distribution of fat. Most men with a ratio greater than 1.0 and women with a ratio greater than 0.85 are at increased risk for cardiovascular disease, diabetes, and cancers.⁵⁹

Skinfold Measurement

Skinfold measurements are used to characterize subcutaneous fat thickness at various regions of the body, but it should be noted that they have limited utility in people who are considered overweight or have obesity. The primary limitation is that most skinfold calipers have an upper measurement limit of 45 to 55 mm, which restricts their use to subjects who are moderately overweight or thinner.² A few skinfold calipers take large measurements, but this is not a significant improvement because of the difficulty of grasping and holding a large skinfold while reading the caliper dial. The majority of national reference data available are for skinfolds at the triceps and subscapular locations. The triceps skinfold varies considerably by sex and can reflect changes in the underlying triceps muscle rather than an actual change in body fatness. The statistical relationships between skinfolds and percent or total body fat in children and adults are often not as strong as that of BMI.⁶⁰ Further, the upper distribution of subcutaneous fat measurements remains unknown because most children and adults who have obesity have not had their skinfolds measured.

Waist-to-hip Ratio

The waist-to-hip ratio is often considered a better measurement than waist circumference alone in predicting disease risk. To calculate the waist-to-hip ratio, a measuring tape is used to measure waist circumference and hip circumference at its widest part. Observational studies have demonstrated that people with “apple-shaped” bodies, (who carry more weight around the waist) have greater risks for chronic disease than those with “pear-shaped” bodies, (who carry more weight around the hips). A study with more than twenty-seven thousand participants from fifty-two countries concluded that the waist-to-hip ratio is highly correlated with heart attack risk worldwide and is a better predictor of heart attacks than BMI.⁶¹ Abdominal obesity is defined by the World Health Organization (WHO) as having a waist-to-hip ratio above 0.90 for males and above 0.85 for females.

Visceral Adiposity Index (VAI)

The Visceral Adiposity Index (VAI) is an empirical-mathematical model, gender-specific, based on simple anthropometric (BMI and WC) and functional parameters (triglycerides (TG) and HDL cholesterol (HDL)), and indicative of fat distribution and function.⁶² It is an empirical-mathematical model that does not originate from theoretical assumptions, but from observation in a healthy normal/overweight population of a linear relationship between BMI and CV, from which a linear equation has been extrapolated. The main strength to consider is that the VAI is an indicator of early cardiometabolic risk in all borderline conditions in which overt metabolic syndrome is not present. This is explained by the fact that three of the variables making up the VAI (WC, TG, and HDL) are all expressed in the criteria for metabolic syndrome. An important limitation to consider is the application of the VAI in non-Caucasian populations and in patients aged less than 16 years.⁵⁸ This is because the mathematical modelling process was done on healthy Caucasian men and women, aged between 19 and 83 years.⁵⁸ A study which evaluated the VAI in children, found that the VAI should be extrapolated with caution in this age range.⁶³ Therefore, VAI is a useful measurement in the following populations: healthy or apparently healthy population with BMI < 40 kg/m², patients with one or two of the 5 components of the metabolic syndrome, women with PCOS, and patients with endocrine disorders (i.e., acromegaly, adult GH deficiency, hypogonadism, hyperprolactinemia, or abnormal thyroid function).⁵⁸

Relative Fat Mass (RFM)

Relative fat mass (RFM) is a simple linear equation based on height-to-waist ratio, and has promise as a potential alternative tool to estimate whole-body fat percentage in women and men 20 years of age and older. One study performed using nationally representative samples of the US adult population which allowed evaluation of the performance of RFM among Mexican Americans, European Americans, and African Americans.⁶⁴ The performance of RFM to estimate body fat percentage was overall more consistent than that of BMI among women and men, across ethnic groups, young, middle-age and older adults, and across quintiles of body fat percentage, although the accuracy of RFM was lower among individuals with lower body fatness.⁶⁰

Hydrostatic weighing (densitometry)

Hydrostatic weighing (underwater weighing), or densitometry, is the difference of the body weight in air and water is used to compute the body's density.⁶⁵ Assuming a two-component model with different densities for fat mass and fat-free mass and correcting for the air volume in the lungs, the total body fat percentage can be estimated. This technique, however, cannot give any measurements of the distribution of adipose tissue or lean tissue (LT).

Air displacement plethysmography (ADP)

ADP, also known under its commercial brand name as BOD POD, measures the overall body density, total body fat and lean tissue but not their distributions.⁶⁶ By putting the body in an enclosed chamber and changing the chamber's volume, the volume of the displaced air (i.e., the volume of the body) can be determined from the changes in air pressure.⁶⁰ Since ADP is based on the same two-component model as hydrostatic weighing, it is also affected by the same confounders, mainly variations in bone mineral content and hydration. Therefore, ADP, as well as hydrostatic weighing, is limited to gross body composition analysis, and not estimates of regional fat or muscles.

Bioelectrical impedance analysis (BIA)

BIA uses the electrical properties of the body to estimate the total body weight and from that the body fat mass.⁶⁷ The body is modeled as five cylindrical lean tissue compartments; the trunk and the four limbs, while fat is considered to be an insulator. The impedance is assumed to be proportional to the height and inversely proportional to the cross-sectional area of each compartment. BIA requires different model parameters to be used depending on age, gender, level of physical activity, amount of body fat, and ethnicity in order to be reliable.⁶⁸

Dual-energy X-ray absorptiometry (DXA)

DXA is a two-dimensional imaging technique that uses X-rays with two different energies. By using two different energy levels, the images can be separated into two components (i.e., bone and soft tissue). DXA is mainly used for bone mineral density measurements, where it is considered as the gold standard, but it can also be used to estimate total and regional body fat and lean tissue mass.⁶⁹ DXA has been found to be more accurate than density-based methods for estimating total body fat.⁷⁰ Due to its ability to estimate regional fat and measure lean tissue, in combination with relatively high availability, DXA has been used for body composition analysis in a wide range of clinical applications and is considered the gold standard for measuring body fat.⁷¹

Computed Tomography (CT) Scan

CT gives a three-dimensional high-resolution image volume of the complete or selected parts of the body, computed from a large number of X-ray projections of the body from different angles. As opposed to the previously described techniques, CT can accurately determine fat in skeletal muscle tissue and in the liver.⁷² In practice, however, CT-based body composition analysis is in most cases limited to two-dimensional analysis of one or a limited number of axial slices of the body. This approach, however, limits its precision since the exact locations of slices, in relation to internal organs, cannot be determined and will vary between scans. Regardless, CT, together with MRI, is today considered the gold standard for body composition analysis, which assessed the proportion of fat to fat-free mass in your body.

Magnetic resonance imaging (MRI)

MRI uses the different magnetic properties of the nuclei of certain chemical elements (normally hydrogen in water and fat) in the cells to produce images of soft tissue in the body. Several MRI-based methods for quantification of adipose tissue and muscles have been developed and implemented.⁷³ MRI is used to obtain precise measurements of regional adipose tissue and lean tissue, as well as diffuse fat infiltration in other organs. However, due to several undeterminable factors affecting the MR signal, an MR image is not calibrated on an absolute scale and therefore cannot be quantitative. But by using different postprocessing techniques, the image can be calibrated to quantitatively measure fat or adipose tissue.⁶⁹

CALCULATING OBESITY IN CHILDREN AND ADOLESCENTS

In the United States, obesity and severe obesity in children and adolescents are defined using threshold values from the 2000 CDC sex-specific body mass index-for-age growth charts.⁷⁴ In addition to defining obesity, BMI z-scores and percentiles are used to monitor children's weight status over time and to evaluate obesity treatments in research settings. Percentiles near the upper limit of 100 percent become less useful for detecting meaningful differences, and therefore percentiles can be converted to z-scores that indicate the number of standard deviations of a value from the mean. However, BMI z-scores (BMIz) and percentiles based on the 2000 BMI-for-age

CDC growth charts (BMIz and BMI percentiles) were never meant to be used to monitor children with extremely high BMI values, and significant limitations exist when they are used to monitor children with severe obesity.⁷⁵ Specifically, BMIz values corresponding to extremely high BMI values are compressed into a very narrow range. Studies on obesity prevalence, its impact, and the availability of effective treatment have highlighted the need for meaningful standardized measures to track extremely high values of BMI in clinical and research settings.

As a result of needing more standardized measures the CDC studied alternative BMI metrics which include:

- BMI (untransformed),
- BMI z-scores and percentiles (modified),
- BMI z-scores and percentiles (extended),
- Percent of 95th percentile BMI units or percent from median, and
- Adjusted BMI units or percent from median.⁷⁶

None of these metrics had the problem of compression at extremely high BMI values, but all had limitations, especially when applied across the weight status spectrum and a wide range of ages. The report however concluded that the extended method for calculating z-scores and percentiles stands out among the alternatives.⁷² First, the extended method improves the characterization of BMI distributions at very high values using nationally representative data, but all other BMI metrics that refer to a reference population (all alternative metrics except untransformed BMI) rely on extrapolating beyond this reference population.⁷² Second, below the 95th percentile, extended BMI z-scores and percentiles preserve CDC 2000 z-scores and percentiles that are currently in use, which allows seamless transitions from the current CDC z-scores and percentiles below the 95th percentile to extended z-scores and percentiles above the 95th percentile.⁷² Alternative BMI metrics other than extended BMIz and percentiles may be appropriate for use in certain scenarios, such as during adolescence when differences among the metrics are less pronounced, when transitions to or from obesity are minimal, or for monitoring BMI changes over short periods when adjusting for expected growth and development is less critical.

INDICATIONS FOR METABOLIC AND BARIATRIC SURGERY

During the HOD Interim meeting in 2022, Resolution 937 “Indications for Metabolic and Bariatric Surgery,” was introduced by the American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons. This resolution called for adoption of the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery. Given that these guidelines depend on BMI, they were referred for consideration in this report.

The American Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) have convened to produce a joint statement on the current available scientific information on metabolic and bariatric surgery and its indications recommending the following updates:

- Metabolic and bariatric surgery (MBS) is recommended for individuals with a body mass index (BMI) ≥ 35 kg/m², regardless of presence, absence, or severity of co-morbidities.
- MBS should be considered for individuals with metabolic disease and BMI of 30-34.9 kg/m².
- BMI thresholds should be adjusted in the Asian population such that a BMI ≥ 25 kg/m² suggests clinical obesity, and individuals with BMI ≥ 27.5 kg/m² should be offered MBS.

- Long-term results of MBS consistently demonstrate safety and efficacy.
- Appropriately selected children and adolescents should be considered for MBS.⁷⁷

It should be noted that the AMA did not participate in the development of these guidelines and therefore cannot endorse these guidelines. AMA policies are also adopted for a period of 10 years with the option of renewal through the Sunset process, therefore it is important to not reference specific guidelines in policy which may change over time.

EXISTING AMA POLICY

Under existing AMA Policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity” the AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m²; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

Policy H-150.928, “Eating Disorders and Promotion of Healthy Body Image,” supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.

Policy H-150.965, “Eating Disorders” notes that the AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors.

CONCLUSIONS

The most basic definition of obesity is having too much body fat, so much so that it presents a risk to health.⁷⁸ A reliable way to determine whether a person has too much body fat is to calculate the ratio of their weight to their height squared. This ratio, called the body mass index (BMI), accounts for the fact that taller people have more tissue than shorter people, and so they tend to weigh more. BMI is not a perfect measure, because it does not directly assess body fat. Muscle and bone are denser than fat, so an athlete or muscular person may have a high BMI, yet not have too much fat. Risk of developing health problems, including several chronic diseases such as heart disease and diabetes, rises progressively for BMIs above 21. There's also evidence that at a given BMI, the risk of disease is higher in some ethnic groups than others.

Critics of BMI note that body fat location is also important and could be a better indicator of disease risk than the amount body fat.⁷⁹ Fat that accumulates around the waist and chest (what is called abdominal adiposity) may be more dangerous for long-term health than fat that accumulates around the hips and thighs. Some researchers have further argued that BMI should be discarded in favor of measures such as waist circumference.⁷⁵ However, this is unlikely to happen given that BMI is easier to measure and has a long history of use. In adults, measuring both BMI and waist circumference may be a better way to predict someone's weight-related risk. In children, however, there is no good reference data for waist circumference, so BMI-for-age is currently the gold standard. Overall, BMI does not describe body fat distribution, so additional anthropometric parameters should be used to assess enhanced accumulation of visceral adipose tissue.

Further, the current BMI classification system is misleading regarding the effects of body fat mass on mortality rates. The role of fat distribution in the prediction of medically significant morbidities as well as for mortality risk is not captured by use of the BMI. Also, numerous comorbidities, lifestyle issues, gender, ethnicities, medically significant familial-determined mortality effectors, duration of time one spends in certain BMI categories, and the expected accumulation of fat with aging are likely to significantly affect interpretation of BMI data, particularly in regard to morbidity and mortality rates. Such confounders as well as the known clustering of obesity in families, the strong role of genetic factors in the development of obesity, the location in which excessive fat accumulates, its role in the development of type 2 diabetes and hypertension, and so on, need to be considered before promulgation of public health policies that are designed to apply to the general population and are based on BMI data alone. Further, the use of BMI is problematic when used to diagnose and treat individuals with eating disorders, because it does not capture the full range of abnormal eating disorders. It should also be noted that the recent increase in fat transfer procedures may complicate BMI measurements and should be further studied.

RECOMMENDATIONS

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

1. Our AMA recognizes:

1. the issues with using body mass index (BMI) as a measurement because: (a) of the eugenics behind the history of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based on the imagined ideal Caucasian and does not consider a person's gender or ethnicity.
2. the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors.
3. that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level.
4. that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.
5. that in some diagnostic circumstances, the use of BMI should not be used as a sole criterion for appropriate insurance reimbursement. (New HOD Policy)

- 1 2. Our AMA supports further research on the application of the extended BMI percentiles and
2 z-scores and its association with other anthropometric measurements, risk factors, and
3 health outcomes. (New HOD Policy)
4
- 5 3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative
6 measures for diagnosing obesity. (New HOD Policy)
7
- 8 4. That our AMA amend policy H-440.866, “The Clinical Utility of Measuring Body Mass
9 Index and Waist Circumference in the Diagnosis and Management of Adult Overweight
10 and Obesity,” to read as follows:
11 The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and
12 Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity,
13 H-440.866
14 Our AMA supports:(1) greater emphasis in physician educational programs on the risk
15 differences ~~among ethnic and age within and between demographic groups~~ at varying
16 levels of adiposity, BMI, body composition, and waist circumference and the importance
17 of monitoring ~~these waist circumference~~ in all individuals ~~with BMIs below 35 kg/m2~~; (2)
18 additional research on the efficacy of screening for overweight and obesity, using different
19 indicators, in improving various clinical outcomes across populations, including morbidity,
20 mortality, mental health, and prevention of further weight gain; and (3) more research on
21 the efficacy of screening and interventions by physicians to promote healthy lifestyle
22 behaviors, including healthy diets and regular physical activity, in all of their patients to
23 improve health and minimize disease risks. (Modify Current HOD Policy).
24
- 25 5. That our AMA amend policy H-150.965, “Eating Disorders” to read as follows: The AMA
26 (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s
27 physical and mental health as obesity; (2) asks its members to help their patients avoid
28 obsessions with dieting and to develop balanced, individualized approaches to finding the
29 body weight that is best for each of them; (3) encourages training of all school-based
30 physicians, counselors, coaches, trainers, teachers and nurses to recognize ~~unhealthy~~
31 abnormal eating behaviors, dieting, and weight restrictive behaviors in adolescents and to
32 offer education and appropriate referral of adolescents and their families for evidence-
33 based and culturally-informed interventional counseling; and (4) participates in this effort
34 by consulting with appropriate, culturally-informed educational and counseling materials
35 pertaining to ~~unhealthy abnormal~~ abnormal eating behaviors, dieting, and weight restrictive
36 behaviors. (Modify Current HOD Policy)
37
- 38 6. That our AMA not adopt Resolution 937-I-22, “Indications for Metabolic and Bariatric
39 Surgery.”

Fiscal Note: less than \$1,000

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⁷⁹ Kragelund C, Omland T. A farewell to body-mass index? *Lancet*. 2005; 366:1589-91.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 08-A-23

Subject: Council on Science and Public Health Sunset Review of 2013 House Policies

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee D

1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. This policy reads as follows, laying out the parameters for review
4 and specifying the needed procedures:

5
6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset
9 the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.

10
11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies
13 that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to
14 the appropriate AMA councils for review; (c) Each AMA council that has been asked to review
15 policies shall develop and submit a report to the House of Delegates identifying policies that are
16 scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one
17 of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or
18 (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it
19 makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent
20 justification (f) The Speakers shall determine the best way for the House of Delegates to handle the
21 sunset reports.

22
23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or
25 has been accomplished.

26
27 4. The AMA councils and the House of Delegates should conform to the following guidelines for
28 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of
31 Delegates Reference Manual: Procedures, Policies and Practices.

32
33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

34
35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

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

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-135.974	Support Stricter OSHA Silica Permissible Exposure Limit Standard	Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL. (Res. 916, I-13)	Rescind; completed. OSHA updated silica standards for industry, maritime, and construction settings in 2016.
D-135.975	Monitoring for Radiation in Seafood	Our AMA calls for the United States government to continue to monitor and fully report the radioactivity levels of edible ocean species sold in the United States. (Res. 414, A-13)	Retain; change to H-policy
D-135.980	Gulf Oil Spill Health Risks and Effects	Our AMA supports efforts by will encourage the National Institute of Environmental Health Sciences and the Natural Resource Damage Assessment program to: (1) continue to monitor health effects (including mental health effects) and public health surveillance activities related to the Gulf oil spill, and provide relevant information and resources as they become available; and (2) monitor the results of studies examining the health effects of the Gulf oil spill and report back as appropriate. (CSAPH Rep. 3, I-10; Modified: CSAPH Rep. 5, A-13)	Retain as amended; change to H-policy.
D-150.981	The Health Effects of High Fructose Syrup	Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars sweeteners , and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars caloric sweeteners in their diet. (CSAPH Rep. 3, A-08; Reaffirmation A-13)	Retain as amended and change to H policy. "Added sugars" is a more encompassing term for caloric sweeteners/sweeteners. The current Dietary Guidelines for American also references added sugars and not caloric sweeteners.
D-150.985	Folic Acid Fortification of Grain Products	Our AMA will : (1) urges the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to supports domestic and international producers of corn grain products, including masa, nixtamal,	Retain as amended; change to H-policy.

		maize, and pozole, to advocate <u>advocating</u> for folic acid fortification of such products. (CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)	
D-150.987	Addition of Alternatives to Soft Drinks in Schools	Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools. (Res. 413, A-05; Reaffirmation A-07; Reaffirmation A-12; Reaffirmation A-13)	Retain; still relevant.
D-20.992	Routine HIV Screening	Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 <u>15-65</u> , and sexually active adolescents under age 15 and adults over 65 at increased risk of infection should also be screened; (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention's (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continues to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant people <u>women</u> in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (54) will identify legal and funding barriers to the implementation of the CDC's HIV testing recommendations and develop strategies to overcome these barriers; (65) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (67) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations. (CSAPH Rep. 2, I-06; Modified: Res. 927, I-10; Reaffirmation I-13)	Retain as amended to align with updated evidence-based guidelines.
D-220.970	Joint Commission Accreditation Standard for Pain Assessment	Our AMA urges <u>supports efforts</u> by The Joint Commission to <u>continuously</u> reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician's abilities to select the most appropriate treatment options for their patients. (Sub. Res. 915, I-13)	Retain as amended; change to H-policy.

D-35.981	AMA Response to Pharmacy Intrusion Into Medical Practice	<p>1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and unwarranted.</p> <p>2. Our AMA will work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing.</p> <p>3. If the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.</p> <p>(Res. 218, A-13)</p>	Retain as amended; change to H-policy.
D-440.935	Strategies to Increase Diabetes Awareness	<p>Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence.</p> <p>(Res. 412, A-13)</p>	Rescind; completed. Launched programs with the YMCA to provide screenings and awareness around diabetes prevention and supported referral of patients to Diabetes Prevention Programs, a lifestyle modification program designed to reduce the risk of developing type 2 diabetes.
D-455.998	Ionizing Radiation Exposure in the Medical Setting	<p>Our AMA will:</p> <p>(1) collaborate with <u>Support</u> appropriate specialty medical societies and other interested stakeholders to convene a meeting <u>collaborate</u> (a) to examine the for feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings; and (b) to discuss methods to <u>continue</u> <u>to</u> educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting;</p> <p>(2) continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health;</p> <p>(3) support education and standards for all providers and medical personnel using ionizing and non-ionizing radiation that includes awareness of, and methods to avoid, patient over-radiation;</p> <p>(4) support policies that promote the safe use of medical imaging devices, informed clinical decision-</p>	Retain as amended; change to H-policy.

		making regarding the use of procedures that use radiation, and patient awareness of medical radiation exposure; and (5) encourage the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving, in both the in-patient and out-patient settings, which will help physicians discuss the potential dangers of high level of radiation exposure with patients. CSAPH Rep. 2, A-06; Appended: Res. 921, I-11; Reaffirmation A-13	
D-455.999	Monitoring Patient Exposure to Ionizing Radiation	1. Our American Medical Association will work with the support public health, radiology and radiation oncology specialty societies and all other interested parties to study monitor the issue of radiation exposure by to the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings. 2. Our AMA: (a) will work with the American College of Radiology, the Radiological Society of North America, and other appropriate specialty medical societies and stakeholders to develop recommendations for a common format for monitoring, quantifying, documenting, and communicating the cumulative radiation exposure sustained by individual patients in medical settings that could be incorporated into a patient's personal health record and present their findings to industry; (b) recommends dissemination and use of the Physician Consortium for Performance Improvement (PCPI) 2007 Radiology Performance Improvement Measures that pertain to radiation exposure monitoring for CT scanning and fluoroscopy, and that the PCPI continue to incorporate radiation exposure issues in future performance measurement sets; and (c) supports physician and patient education on the appropriate use and risks of radiation in the medical setting. Res. 521, A-05; Appended: BOT Rep. 12, I-09; Reaffirmation A-13	Retain as amended; change to H-policy. Part two of the resolution is complete.
D-460.983	Translating Biomedical Research to the Bedside	Our AMA will: (1) give high priority to bringing promising biomedical research to the bedside; and (2) advocate for the elimination of unreasonable barriers to bedside care using new research. (Res. 812, I-03; Modified: CSAPH Rep. 1, A-13)	Retain; change to H policy.
D-490.983	Annual Tobacco Report 2003	Our AMA will continue to produce the Annual Tobacco Report. (BOT Rep. 7, I-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
D-515.985	Elder Mistreatment	Our AMA: 1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams	Retain; change to H policy.

		<p>and assume greater roles as medical advisors to APS services.</p> <p>2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.</p> <p>3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.</p> <p>4. Encourages substantially more research in the area of elder mistreatment.</p> <p>5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.</p> <p>6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated.</p> <p>7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation.</p> <p>(CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13)</p>	
D-55.998	Encourage Appropriate Colorectal Cancer Screening	Our AMA, in conjunction with interested organizations and societies, will supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high risk groups. (Res. 510, A-03; Modified: CSAPH Rep. 1, A-13)	Retain as amended; change to H policy.
H-10.966	Prevention of Fires Related to Cigarette Smoking	The AMA (1) supports studies to determine the feasibility and practicality of establishing a standard for self-extinguishing cigarettes and requiring cigarette manufacturers to meet that standard; (2) supports the concept of self-extinguishing cigarettes for the purpose	Retain; still relevant.

		of reducing fire related deaths, injuries and loss of property; and (3) reiterates its opposition to all smoking. (Sub. Res. 6, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-10.981	Prohibition on the Public Sale of Fireworks	Our AMA (1) encourages accurate reporting of fireworks related injuries, deaths, and fires; (2) supports all efforts designed to prohibit the public sale, including those by mail order, of all fireworks; (3) supports existing efforts to educate physicians, parents, children, and community leaders about the dangers of fireworks; and (4) encourages the adoption of federal legislation prohibiting the sale of fireworks and their use, with the exception of those used for professional displays. (Res. 419, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-10.995	Use of Technology to Prevent Explosions	The AMA encourages manufacturers of automobiles, boats, and other vehicles, as well as makers of containers of volatile liquids and gases, to incorporate appropriate safety technology into the development of their products. (Res. 59, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-100.976	Benzodiazepine Education	Our AMA encourages physicians interested in the addictive nature of benzodiazepines and their rational use to seek information from appropriate sources. (CSA Rep. E, A-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-130.992	Proposed Crisis Relocation and Shelter Plans	Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude. (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; duplicative of more comprehensive policy (H-130.942 , D-130.972 , and D-130.974).
H-130.993	Use of Emergency Medical Information Aids	The AMA (1) endorses and encourages the use of effective medical information aids by which appropriate individual medical information can be brought to the attention of emergency personnel; and (2) supports continued review of existing medical information aids to determine appropriate steps to encourage greater use of those information aids which are considered effective. (Res. 57, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended.
H-135.948	Toxicity of Computers and Electronics Waste	Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous	Retain; still relevant.

		<p>electronic waste to developing countries and safely dispose of the waste that <u>cannot</u> be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials.</p> <p>(Res. 423, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
H-135.961	Risks of a High-Level Radioactive Waste Repository	<p>The AMA (1) strongly encourages the U.S. Nuclear Regulatory Commission and the Nuclear Waste Technical Review Board of the National Research Council to include representatives of the appropriate state medical societies/associations, the AMA, and appropriate medical specialty groups with expertise in the field to advise and/or act as consultants to those entities; and (2) urges the U.S. Congress to establish a site for a high-level radioactive waste repository.</p> <p>(BOT Rep. A, I-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-145.978	Gun Firearm Safety	<p>Our AMA: (1) recommends and promotes the use of trigger locks and locked gun <u>firearm</u> cabinets as safety precautions; and (2) endorses <u>supports</u> standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.</p> <p>(Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)</p>	Retain as amended; still relevant. Terminology updated for consistency.
H-145.988	AMA Campaign to Reduce Firearm Deaths	<p>The AMA supports educating the public regarding methods to reduce death and injury due to keeping <u>firearms</u> guns, ammunition and other explosives in the home.</p> <p>(Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)</p>	Retain as amended; still relevant. Terminology updated for consistency.
H-15.954	Older Driver Safety	<p>(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and:</p> <p>(a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly;</p> <p>(b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving</p>	Retain; still relevant.

		<p>safety cannot be maintained through medical interventions or driver rehabilitation;</p> <p>© urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and</p> <p>(d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting.</p> <p>(2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients. (CSA Rep. 6, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
H-15.964	Police Chases and Chase-Related Injuries	<p>The AMA encourages (1) communities, aided by government officials and medical scientists, to develop <u>and implement</u> guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.</p> <p>(CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain as amended. In 2015, a model policy was created by the International Association of Chiefs of Police. In it, the policy states, "Pursuit is authorized only if the officer has a reasonable belief that the suspect, if allowed to flee, would present a danger to human life or cause serious injury. In general, pursuits for minor violations are discouraged"
H-150.966	FDA Regulations Regarding the Inclusion of Added L-Glutamic Acid Content on Food Labels	<p>Until such time as L-glutamic acid in any form has been shown to pose a significant public health hazard or until biological non-equivalence of monosodium glutamate and L-glutamate has been demonstrated, the AMA supports the exclusion of L-glutamic acid released from hydrolyzed protein from food product labeling requirements.</p> <p>(CSA Rep. D, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-170.965	Education on Condom Use	<p>Our AMA: (1) Supports joining with appropriate medical and public health organizations and federal agencies in endorsing the use of condoms in reducing the risk of HIV/AIDS and other sexually transmissible diseases among the population; (2) Encourages the production of condom education materials that meet standards of accuracy, completeness, social appropriateness, clarity, and simplicity; (3) Supports cooperating with other medical societies, the public health community, government agencies, and the media to develop standards for public service announcements regarding condom use in prevention of HIV/AIDS and other sexually transmissible diseases; and (4) In cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about the role of condom use in reducing the risk of sexually transmissible diseases, including HIV</p>	Retain; still relevant.

		disease. While such counseling may not be appropriate for all patients, physicians should be encouraged to provide this information to any patient who may benefit from being more aware of the risks of sexually transmissible diseases. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-170.966	Human Sexuality Education	Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; Duplicative of policy H-170.968
H-170.967	Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System	Our AMA supports comprehensive health education for female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for girls who have been victimized. (Res. 411, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind; more recent policy exists including D-60.994 , D-430.997 , and H-515.981 .
H-175.992	Deceptive Health Care Advertising	Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising. (Sub. Res. 102, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 13, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 6, A-13)	Retain; still relevant.
H-20.899	HIV Testing	Our AMA endorses routine HIV screening/testing for individuals on admission to the hospital, visit to the emergency room or doctor's office as deemed appropriate by the attending physician. It is AMA policy that: (1) this testing should be a voluntary program in which patients may opt out if they desire not to be tested; (2) HIV screening permission be incorporated into general health care consent forms and that separate written consent is not recommended; (3) prevention counseling should not be a requirement for this testing program; (4) when tests are positive, appropriate public health measures be instituted for surveillance, prevention of transmission and dissemination of the virus; and (5) when positive HIV patients are identified, appropriate linkage to HIV care be established. (Res. 2, A-07; Reaffirmation I-13)	Rescind; Duplicative of H-20.920
H-20.903	HIV/AIDS and Substance Abuse	Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that <u>people who use drugs</u> abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among <u>persons who inject drugs</u> intravenous drug abusers ; (2) advocates development of regulations and incentives to encourage retention of HIV-positive	Retain as amended; updating language.

		<p>and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of <u>persons who inject drugs intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic</u>. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for <u>persons who inject drugs intravenous drug abusers</u> and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant <u>people who inject drugs intravenous drug abusers</u> and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers <u>users</u>, especially homeless, runaway, and detained adolescents who are <u>living with HIV seropositive or AIDS symptomatic</u> and those whose lifestyles with risk factors place them at risk for contracting HIV infection. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-20.907	Financing Care for HIV/AIDS Patients	<p>Our AMA:</p> <p>(1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;</p> <p>(2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;</p> <p>(3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;</p> <p>(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;</p>	Retain as amended; still relevant.

		<p>(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;</p> <p>(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;</p> <p>(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;</p> <p>(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.</p> <p>(CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)</p>	
H-20.910	HIV-Infected Children	<p>Our AMA:</p> <p>(1) Supports day-care, preschool, and school attendance of HIV-infected children;</p> <p>(2) Encourages the physician responsible for care of an HIV-infected child in a day-care, preschool, or school setting to receive information from the school on other infectious diseases in the environment and temporarily remove the HIV-infected child from a setting that might pose a threat to his/her health;</p> <p>(3) Encourages that HIV-infected children who are adopted or placed in a foster-care setting have access to special health care benefits to encourage adoption or foster-care.</p> <p>(CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-20.916	Breastfeeding and HIV Seropositive Women <u>People</u>	<p>Our AMA believes that, where safe and alternative nutrition is widely available, HIV seropositive women <u>people</u> should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption.</p> <p>(CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain as amended to include gender-neutral language.
H-20.917	Neonatal Screening for HIV Infection	<p>Our AMA: (1) urges the U.S. Public Health Service, other appropriate federal agencies, private researchers, and health care industries to continue to pursue research, development, and implementation of diagnostic tests and procedures for more accurate demonstration of HIV infection in the newborn; and supports the widespread use of such tests in early diagnosis; (2) favors giving consideration to rapid HIV testing of newborns, with <u>maternal</u> consent <u>of the</u></p>	Retain as amended.

		gestational parent , when the maternal individual's HIV status has not been determined during pregnancy or labor; and (3) supports mandatory HIV testing of all newborns in high prevalence areas. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)	
H-20.919	Patient Disclosure of HIV Seropositivity	Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-245.983	Baby Walkers	The AMA strengthens its policy on baby walkers by <u>urging</u> urges the Consumer Product Safety Commission to ban infant walkers as a mechanical hazard. (Res. 403, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-245.985	Mandatory Labeling for Waterbeds and Beanbag Furniture	The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. (Res. 414, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-280.958	Pain Control in Long-Term Care	Our AMA will work: (1) to promote <u>promulgate</u> clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients. (Res. 715, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 518, A-12; Reaffirmation A-13)	Retain as amended to clarify the AMA's role in clinical practice guidelines.
H-365.996	Regulation of Occupational Carcinogens	The AMA endorses the principle of <u>supports</u> using the best available scientific data, including data derived from animal models, as a basis for regulation of occupational carcinogens. (Sub. Res. 81, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-370.984	Organ Donation Education	Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes. (Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Modified: Res. 3, A-13)	Retain; still relevant.
H-420.991	Fetal Effects of Maternal Alcohol Use	The AMA believes that (1) The evidence is clear that a woman <u>person</u> who drinks heavily during pregnancy places her <u>their</u> unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse <u>use</u> and alcoholism <u>alcohol use disorder</u> in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as	Retain as amended; still relevant.

		<p>possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group.</p> <p>(2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal <u>gestational</u> alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal <u>gestational</u> alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent.</p> <p>(3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence.</p> <p>(4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake.</p> <p>(5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations.</p> <p>(6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal <u>gestational</u> drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations. (CSA Rep. E, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	
H-425.971	Celiac Disease Screening	Our AMA: (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (Res. 419, A-13)	Retain; still relevant.
H-430.988	Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities	<p>(1) Medical Testing and Care of Inmates Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners inmates should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d)</p>	Retain as amended; updating language to be consistent with current policy.

		<p>Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners <u>Inmates</u> should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-440.842	Recognition of Obesity as a Disease	Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. (Res. 420, A-13)	Retain; still relevant.
H-440.843	Health Risks of Sitting	Our AMA recognizes that there are potential risks of prolonged sitting, encourages efforts by employers, employees, and others to make available alternatives such as standing work stations and isometric balls, and encourages educational efforts regarding ways to minimize this risk. (Res. 413, A-13)	Retain; still relevant
H-440.866	The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity	Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m ² ; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in	Retain; still relevant.

		<p>improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and</p> <p>(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.</p> <p>(CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13)</p>	
H-440.898	Recommendations on Folic Acid Supplementation	<p>Our AMA will:</p> <p>(1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD);</p> <p>(2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD;</p> <p>(3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states;</p> <p>(4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products;</p> <p>(5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and</p> <p>(6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and</p> <p>(7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06; Reaffirmed: CSAPH Rep. 1, I-13)</p>	Retain; still relevant.
H-440.931	Update on Tuberculosis	<p>It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its</p>	Retain as amended; updating language.

		transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added. (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-440.934	Adequacy of Sterilization in Commercial Enterprises	The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-440.966	Elimination of Tuberculosis as a Public Health Problem	The AMA (1) endorses the Strategic Plan for the Elimination of Tuberculosis, as developed by the CDC <u>Division of Tuberculosis Elimination</u> Advisory Committee for the Elimination of Tuberculosis ; (2) supports cooperative efforts with other national medical and public health organizations to help implement the policies of the Strategic Plan for the Elimination of Tuberculosis; (3) supports the promulgation of information on the appropriate methods for evaluating, diagnosing, treating, and preventing tuberculosis; (4) encourages and assists state and county medical associations to work with state, county and city health officials to achieve the long-range objective of reducing the incidence of active tuberculosis in the United States to one case per million before the year 2010 ; and (5) supports use of a tuberculosis risk assessment questionnaire in US school aged children when appropriate, with follow-up TB testing based on the results of that TB risk assessment. (Res. 75, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Appended: Res. 515, A-13)	Retain as amended; updated language to be consistent with the current goals.
H-455.980	National Biomedical Tracer Facility	The AMA supports the establishment of a National Biomedical Tracer Facility with federal funding to serve as a national resource for clinical medicine, research and education. (Res. 513, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.

H-455.994	Risks of Nuclear Energy and Low-Level Ionizing Radiation	<p>Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.</p> <p>(2) Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.</p> <p>(3) Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.</p> <p>(4) Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning. Local laws should be modified to allow the disposal of low level radioactive waste materials in accordance with AMA model state legislation.</p> <p>(5) Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.</p> <p>(6) Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.</p> <p>(7) Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.</p> <p>(8) Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local</p>	Retain as amended; still relevant.
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		<p>governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.</p> <p>(9) Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.</p> <p>(10) Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.</p> <p>(11) Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.</p> <p>(12) Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.</p> <p>(13) Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.</p> <p>(14) Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy.</p> <p>(15) X-Ray Security Scanners: Our AMA: (1) believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks; and (2) supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.</p> <p>(CSA Rep. A, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: CSAPH Rep. 4, A-13)</p>	
H-460.903	Commercialized Medical Screening	<p>Our AMA supports the funding of well-designed, large-scale clinical trials aimed at determining the safety, value, and cost-effectiveness of screening imaging procedures.</p> <p>(CSA Rep. 10, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-460.915	Cloning and Stem Cell Research	<p>Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood</p>	Retain; still relevant.

		stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology. (CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-470.972	Medical and Nonmedical Uses of Anabolic-Androgenic Steroids	Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs; (2) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and (3) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis. (CSA Rep. A, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-01; Modified: CSA Rep. 9, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.956	Commercialized Medical Screening	AMA policy is that relevant specialty societies continue to evaluate the validity and clinical use of screening imaging procedures that are advertised directly to the public and make available to the broader physician community unbiased evaluations to help primary care physicians advise their patients of the risks and benefits of these procedures. (CSA Rep. 10, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.966	Multiplex DNA Testing for Genetic Conditions	Policy of the AMA is that: (1) tests for more than one genetic condition should be ordered only when clinically relevant and after the patient or parent/guardian has had full counseling and has given informed consent; (2) efforts should be made to educate clinicians and society about genetic testing; and (3) before genetic testing, patients should be counseled on the familial implications of genetic test results, including the importance of sharing results in instances where there is a high likelihood that a relative is at risk of serious harm, and where the relative could benefit from early monitoring or from treatment. (CEJA Rep. 1, I-96; Appended: BOT Rep. 16, I-99; Modified: CSA Rep. 3, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-480.978	Medical Innovations	It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers.	Retain; still relevant.

		(Sub. Res. 508, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	
H-485.995	TV Violence	The AMA reaffirms its vigorous opposition to television violence and its support for efforts designed to increase the awareness of physicians and patients that television violence is a risk factor threatening the health of young people. (Res. 19, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)	Retain, still relevant.
H-490.906	Enhanced Education for Abrupt Cessation of Smoking	Our AMA encourages research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals. (Res. 408, A-13)	Retain; still relevant.
H-490.914	Tobacco Prevention and Youth	(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material; (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or <u>childcare</u> purposes; (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities; (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign. (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;	Retain as amended; still relevant.

		<p>(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;</p> <p>(7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;</p> <p>(8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and</p> <p>(9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).</p> <p>(CSA Rep. 3, A-04; Modified: Res. 402, A-13)</p>	
H-495.985	Smokeless Tobacco	<p>Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA:</p> <p>(1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs;</p> <p>(2) objects strongly to the introduction of "smokeless" cigarettes;</p> <p>(3) opposes the use of smokeless tobacco products by persons of all ages;</p> <p>(4) urges that the same requirements and taxes placed on cigarette sales and advertising be applied to smokeless tobacco products;</p> <p>(5) supports legislation to prohibit the sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on purchasing and distributing all tobacco products to individuals under the age of 21 years;</p> <p>(6) supports public and school educational programs on the health effects of smokeless tobacco products;</p> <p>(7) urges the commissioners of professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and recommends that</p>	Retain; still relevant.

		professional athletes participate in media programs that would discourage the youth of America from engaging in this harmful habit; and (8) is committed to exerting its influence to limit exposure of young children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers take steps to diminish the appeal of snuff and chewing tobacco to young persons. (CSA Rep. 3, A-04; Reaffirmation A-13)	
H-5.985	Fetal Tissue Research	The AMA supports the use of fetal tissue obtained from induced abortion for scientific research. (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.975	Safety of Blood Donations and Transfusions	Our AMA: (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion; (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS; (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and (4) Supports providing educational information to physicians on alternatives to transfusion. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.976	Blood Bank Look-Back Programs	Our AMA supports the concept of blood bank look-back recipient notification programs as a means of protecting patients and reducing the possible spread of infections. (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.977	Blood Donor Recruitment	Our AMA: (1) supports the establishment of a national volunteer blood donor education and recruitment campaign to assure an adequate and readily available blood supply; and (2) supports scientifically-based policies that ensure the safety of the nation's blood supply. (Sub. Res. 401, A-02; Modified: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-50.982	Autologous Blood Transfusions	The AMA (1) supports the collection of autologous blood from candidates for elective surgery who are without contraindications to phlebotomy and when such donations are medically indicated because transfusion is likely to be needed; and (2) supports efforts to remove economic barriers to the collection and use of autologous blood for transfusion, in order to promote its wider use. (CSA Rep. A, I-92; Modified: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-515.981	Family Violence-Adolescents as Victims and Perpetrators	The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider	Retain; still relevant.

		<p>issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.</p> <p>(CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-515.982	Violent Acts Against Physicians	<p>Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity; (3) will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers; and (4) will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise.</p> <p>(Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13)</p>	Retain; still relevant.
H-60.925	Effects of Alcohol on the Brains of Underage Drinkers	<p>Our AMA supports creating a higher level of awareness about the harmful consequences of underage drinking. (CSA Rep. 11, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-60.926	Prevention of Falls Through Windows	<p>Our AMA: (1) supports the use of window guards and devices that prevent children from falling through windows; and (2) supports public education regarding the risks of children falling through windows.</p> <p>(Res. 415, A-13)</p>	Retain; still relevant.
H-60.941	Effects of Alcohol on the Brains of Underage Drinkers	<p>Our AMA encourages increased medical and policy research on the harmful effects of alcohol on adolescents and young adults and on the design and implementation of environmental strategies to reduce youth access to, and high consumption of, alcohol.</p>	Retain as amended; still relevant.

		(CSA Rep. 11, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	
H-60.945	Neonatal Male Circumcision	<p>1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.</p> <p>2. Our AMA encourages state Medicaid reimbursement of neonatal male circumcision.</p> <p>(CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 503, A-13)</p>	Retain as amended; still relevant.
H-60.963	Preventable Airway Obstructions in Children	<p>The AMA supports educational programs to apprise the public of the dangers of airway obstruction hazards in children and on methods to prevent these hazards.</p> <p>(Res. 412, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.
H-60.973	Provision of Health Care and Parenting Classes to Adolescent Parents	<p>1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.</p> <p>2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school.</p> <p>(Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13)</p>	Retain; still relevant.
H-60.975	Political Influence and the NIH	<p>Our AMA (1) reaffirms its support for the long standing, uniformly accepted and merit-based scientific peer review system utilized by federal research agencies, including the National Institutes of Health; and (2) deplores the use of political influence to override decisions to support research proposals when those decisions were derived from scientific peer review.</p> <p>(Res. 526, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 725, I-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain; still relevant.

H-75.994	Contraception and Sexually Transmitted Diseases <u>Infections</u>	Our AMA, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted diseases <u>infections</u> , including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexually transmitted diseases <u>infections</u> . (BOT Rep. E, A-89; Reaffirmation A-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-90.977	Impairment and Disability Evaluations	It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations. (CSA Rep. 8, I-99; Reaffirmed and Title Change: CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain; still relevant.
H-95.954	The Reduction of Medical and Public Health Consequences of Drug <u>Use Abuse</u>	Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug misuse <u>abuse</u> aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5)	Retain as amended; still relevant.

		encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients <u>who inject drugs with injection drug addiction</u> in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)	
H-95.956	Harm Reduction Through Addiction Treatment	The AMA endorses <u>supports</u> the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of <u>alcohol use disorders</u> alcoholism and other drug dependencies <u>substance use disorders</u> and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy. (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain as amended; still relevant.
H-95.961	Policy on Illegal <u>Illicit</u> Drug Use	The AMA discourages and condemns illegal <u>illicit</u> drug use, and encourages physicians to do all in their power to discourage the use of illegal <u>illicit</u> drugs in their communities and to refuse to assist anyone in obtaining drugs for non-medical use. (Res. 523, A-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Rescind based on stigmatizing language and discordance with more recent policy.
H-95.984	Issues in Employee Drug Testing	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	Retain; still relevant.

		care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13)	
H-95.997	Cannabis Intoxication as a Criminal Defense	Our AMA believes a plea of cannabis intoxication not be a defense in any criminal proceedings. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)	Retain; still relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-23)

Introduced by: Washington

Subject: Metered Dose Inhalers and Greenhouse Gas Emissions

Referred to: Reference Committee D

1 Whereas, Climate change is a risk multiplier that threatens to unravel decades of development
2 gains; and
3

4 Whereas, Nearly 10% of all US greenhouse gas emissions are from health care; and
5

6 Whereas, The house of medicine has a responsibility to limit its contribution to climate change
7 because of its impact on human health; and
8

9 Whereas, The use of hydrofluorocarbons is a known contributor to climate change; and
10

11 Whereas, Metered-dose inhalers (MDIs) use hydrofluorocarbons as a propellant, making a
12 significant contribution to the health care sector's greenhouse gas emissions; and
13

14 Whereas, MDIs remain an important part of asthma and COPD care and need to still be
15 available, as dry-powdered inhalers are not the best option for everyone, dry-powdered inhalers
16 nonetheless have been shown to have equal or superior efficacy and tolerability to MDIs, and
17 thus should be developed and made available; therefore be it
18

19 RESOLVED, That our American Medical Association study the climate effects of metered-dose
20 inhalers, options for reducing hydrofluorocarbon use in the medical sector, and strategies for
21 encouraging the development of alternative inhalers with equal efficacy and less adverse effect
22 on our climate. (Directive to Take Action)

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

Received: 2/14/23

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2. Market Characterization of the US Metered Dose Inhaler Industry. Stratospheric Protection Division of the US EPA. 2021. Access at: https://www.epa.gov/sites/default/files/2021-03/documents/epa-hq-oar-2021-0044-0002_attachment_1-mdis.pdf?VersionId=EonCVwZG6UXYmpe9hmej95NIM0B2zUlr
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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.

2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19;

Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-23)

Introduced by: Young Physicians Section

Subject: Encouraging Discussion of Family Planning Counseling as Part of
Recommended Routine Health Maintenance

Referred to: Reference Committee D

1 Whereas, According to several organizations, for couples in which the female partner is under
2 35 years of age, "infertility is a disease historically defined by the failure to achieve a successful
3 pregnancy after 12 months or more of regular, unprotected sexual intercourse"¹; and
4

5 Whereas, Infertility affects 10-15% of couples,² but affects approximately 25% of female
6 physicians, with the rate of female physicians seeking fertility evaluation and treatment at six
7 times higher than that of the general population^{3, 4, 5}; and
8

9 Whereas, Women of advanced maternal age have increased risks of adverse pregnancy
10 outcomes, including lower chances of live birth and increased risks of miscarriage and birth
11 defects⁶; and
12

13 Whereas, The peak child-bearing years unfortunately correspond to the peak career-building
14 years for many; and
15

16 Whereas, According to the American College of Obstetricians and Gynecologists and the
17 American Society for Reproductive Medicine, "the goal of pre-pregnancy care is to reduce the
18 risk of adverse health effects for the woman, fetus, and neonate by working with the woman to
19 optimize health, address modifiable risk factors, and provide education about healthy
20 pregnancy"⁷; and
21

22 Whereas, "Pre-pregnancy counseling is appropriate whether the reproductive-aged patient is
23 currently using contraception or planning pregnancy. Because health status and risk factors
24 can change over time, pre-pregnancy counseling should occur several times during a woman's
25 reproductive lifespan, increasing her opportunity for education and potentially maximizing her
26 reproductive and pregnancy outcomes"⁷; and
27

28 Whereas, "Many chronic medical conditions such as diabetes, hypertension, psychiatric illness,
29 and thyroid disease have implications for pregnancy outcomes, and should be optimally
30 managed before pregnancy"⁷; and
31

32 Whereas, "Male infertility may occasionally be the presenting manifestation of an underlying life-
33 threatening condition," and so the evaluation of the infertile male includes identification of "life-
34 or health-threatening conditions that may underlie... fertility or associated medical comorbidities
35 that require medical attention"⁸; and
36

37 Whereas, "The burden of infertility includes psychological, social and physical suffering.
38 Documented consequences include: anxiety, depression, lowered life satisfaction, grief, fear,
39 guilt, helplessness, reduced job performance, marital duress, dissolution and abandonment;

1 economic hardship, loss of social status, social stigma, social isolation and alienation,
2 community ostracism, and physical violence”^{9, 10, 11, 12}; and
3

4 Whereas, The consequences of unwanted childlessness can “vary considerably, from an almost
5 universal decrease in well-being in infertile individuals, to significant emotional and
6 psychological effects, disruption in social relationships and, at the severe end of the spectrum,
7 death due to domestic violence, suicide or starvation and disease exacerbated by neglect”^{9, 10}. ;
8 and
9

10 Whereas, “It is often argued that public resources should not be used to help infertile couples
11 reproduce when the planet is already home to a huge (and growing) population which may not
12 be able to be sustainably supported,” but this overpopulation argument “denies the importance
13 of reproductive autonomy and distributes social responsibility for population pressures unfairly
14 on the infertile”^{9,10}; and
15

16 Whereas, “Infertility is often denied classification as a public health issue because of concerns
17 over the cost of treatment,” but cost-effective and creative solutions to infertility (such as
18 preventing STIs) are potentially available, and infertility treatment should be considered part of
19 international efforts to promote women’s reproductive health¹⁰; and
20

21 Whereas, The discipline of public health can should be used to address infertility, by raising
22 awareness of the scope and significance of unwanted childlessness, improving collection and
23 surveillance of health data, generating informed public debate, and developing public policies on
24 infertility and its treatment; and
25

26 Whereas, The U.S. Preventive Services Task Force¹³ works to improve the health of people
27 nationwide by making evidence-based recommendations about clinical preventive services;
28 therefore be it
29

30 RESOLVED, That our American Medical Association work with other stakeholders to encourage
31 discussion of family planning counseling with all individuals with reproductive potential as part of
32 routine health maintenance. (Directive to Take Action)

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

Received: 3/17/23

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RELEVANT AMA POLICY

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving **preconception health care** that state:

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of **preconception** health behaviors and **preconception care** services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary **care** visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to **preconception** risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
- (5) Inter-conception **care**--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
- (6) Pre-pregnancy checkup--offer, as a component of maternity **care**, one pre-pregnancy visit for couples and persons planning pregnancy;
- (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception **care**;
- (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
- (9) Research--increase the evidence base and promote the use of the evidence to

improve **preconception** health; and

(10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor **preconception** health.

2. Our AMA supports the education of physicians and the public about the importance of **preconception care** as a vital component of a woman's reproductive health.

3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-**care** and recommend it be appropriately documented in the medical record.

Citation: Res. 414, A-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17Appended: Res. 401, A-19

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

Resident and Fellow Access to Fertility Preservation H-310.902

Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

Citation: Res. 302, A-22;

E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover **assisted reproductive** services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients.

Physicians who offer **assisted reproductive** services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-23)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and
Detention Centers

Referred to: Reference Committee D

1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people
2 who have been accused and/or convicted of a crime¹; and
3

4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,
5 people awaiting trial or sentence, or young offenders for short periods of time²; and
6

7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual
8 confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary
9 violations in correctional facilities and detention centers³; and
10

11 Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as
12 not standing up for headcount or not returning a food tray^{3,4}; and
13

14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means
15 of reprisal for reporting unsafe and unsanitary conditions^{5,6}; and
16

17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of
19 infectious disease⁷; and
20

21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary
23 measure overseen by medical professionals who treat prisoners with compassion and provide
24 prisoners resources to aid their recovery⁷; and
25

26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around
27 60,000 people, currently reside in some form of solitary confinement⁸; and
28

29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average
30 of \$75,000 per prisoner per year⁹; and
31

32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are
33 offered few or no educational, vocational, or rehabilitative programs¹⁰; and
34

35 Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated
36 with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic
37 stress disorder, and psychosomatic behavior changes¹¹⁻¹³; and

1 Whereas, There is a strong association between solitary confinement and self-harm, for
2 instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher
3 suicide rate within the first year after release and another study analyzing over 240,000
4 incarcerations found that prisoners who experienced solitary confinement accounted for over
5 50% of self-harm incidents despite accounting for only 7.3% of prison admissions^{4,13,14}; and
6

7 Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an
8 opioid overdose in the first two weeks after release and 24% more likely to die from any cause
9 in the first year after release, even after controlling for potential confounding factors, including
10 substance use and mental health disorders¹⁴; and
11

12 Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a
13 higher overall 5-year mortality than those who do not¹⁵; and
14

15 Whereas, A United States Department of Justice study indicates that inmates with mental
16 illnesses are more likely to be put in solitary confinement and that solitary confinement further
17 exacerbates their mental illnesses¹⁶; and
18

19 Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term
20 neurobiological consequences, increasing mentally ill prisoners' need for psychiatric
21 services^{12,13}; and
22

23 Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of
24 homelessness and unemployment after release, in part due to the lasting psychological stress
25 of confinement¹⁷; and
26

27 Whereas, Spending any amount of time in solitary confinement is associated with two times the
28 risk of being reincarcerated within two weeks of release and other studies found a 10-25%
29 increased overall risk of recidivism^{14,18-20}; and
30

31 Whereas, Parolees released from solitary confinement commit new crimes in their community
32 35% more than parolees released from the general prison population, threatening community
33 safety¹⁹; and
34

35 Whereas, Transitioning prisoners from solitary confinement to the general prison population
36 prior to release reduces recidivism rates²⁰; and
37

38 Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions,
39 certain racial minorities are disproportionately more likely to be placed in solitary confinement
40 while white prisoners are 14% less likely to be placed in solitary confinement⁸; and
41

42 Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will
43 be placed in solitary confinement are 80% greater than heterosexual men and the odds are
44 190% greater that lesbian and bisexual women will be placed in solitary confinement than
45 heterosexual women²¹; and
46

47 Whereas, The United Nations and The International Convention on the Rights of the Child
48 prohibit the solitary confinement of anyone under the age of 18^{22,23}; and
49

50 Whereas, In 2015 the United Nations General Assembly adopted "The Standard Minimum
51 Rules for the Treatment of Prisoners," also known as the "Mandela Rules," which condemn the

1 use of solitary confinement for prisoners with mental or physical disabilities when their
2 conditions would be exacerbated by such measures²³; and

3
4 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than
5 15 days, because it is “cruel, inhuman or degrading treatment or punishment”²³; and

6
7 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in
8 exceptional cases as a last resort, for as short a time as possible and subject to independent
9 review”²³; and

10
11 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical
12 and psychological health issues, and should be considered cruel and unusual punishment and a
13 human rights violation²⁴; and

14
15 Whereas, At least some United States correctional facilities have managed to reform and
16 reduce their use of solitary confinement in order to better respect the dignity and human rights
17 of inmates while still maintaining the safety of correctional officers and inmates in jails and
18 prisons¹⁸; and

19
20 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%
21 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff
22 violence¹⁸; and

23
24 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement
25 population, violent incidents also dropped by nearly 70%¹⁹; and

26
27 Whereas, A 2015 study found that placing male inmates who were violent in solitary
28 confinement did not effectively deter or alter the probability, timing, or development of future
29 misconduct or violence²⁵; and

30
31 Whereas, Some correctional facilities have created special units to protect vulnerable groups
32 together with similar access to privileges and programs available to the general population
33 without using solitary confinement as a means of protection¹⁸; and

34
35 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for
36 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New
37 York City²⁶; and

38
39 Whereas, American Medical Association policy H-60.922 opposes the use of solitary
40 confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

41
42 RESOLVED, That our American Medical Association policy H-430.983 be amended by addition
43 and deletion to read as follows:

44
45 **Reducing Opposing the Use of Restrictive Housing in for**
46 **Prisoners with Mental Illness H-430.983**

47 Our AMA will: (1) ~~support limiting~~ oppose the use of solitary
48 confinement of any length, ~~with rare exceptions~~, for incarcerated
49 persons ~~with mental illness~~, in ~~adult~~ correctional facilities and
50 detention centers, except for medical isolation or to protect
51 individuals who are actively being harmed or will be immediately
52 harmed by a physically violent individual, in which cases

1 confinement may be used for as short a time as possible; and (2)
 2 while solitary confinement practices are still in place, support
 3 efforts to ensure that the mental and physical health of all
 4 individuals placed in solitary confinement are regularly monitored
 5 by health professionals; and (3) encourage appropriate
 6 stakeholders to develop and implement safe, humane, and ethical
 7 alternatives to solitary confinement for incarcerated persons in all
 8 correctional facilities; and (3) encourage appropriate stakeholders
 9 to develop and implement alternatives to solitary confinement for
 10 incarcerated persons in all correctional facilities. (Modify Current
 11 Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Citation: Res. 412, A-18;

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Citation: Res. 001, A-18;

Support of Human Rights and Freedom H-65.965

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

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22;

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Citation: (Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15)

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Citation: (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14)

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoners genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-23)

Introduced by: Medical Student Section

Subject: Additional Interventions to Prevent Human Papillomavirus (HPV) infection
and HPV-Associated Cancers

Referred to: Reference Committee D

1 Whereas, Human papillomavirus (HPV) is the most common sexually transmitted infection and
2 is known to cause cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancer¹; and
3

4 Whereas, Smoking, immunosuppression, a history of Chlamydia infection, long term oral
5 contraceptive use, and an increased number of sexual partners is associated with higher risk of
6 developing cervical cancer^{1,2}; and
7

8 Whereas, No current screening test exists to detect HPV infection in people who have penises⁴;
9 and
10

11 Whereas, No current screening test exists to detect HPV infection in the oropharynx⁴; and
12

13 Whereas, From 1995-2012, the proportion of oropharyngeal squamous cell carcinomas driven
14 by HPV infection increased substantially in people with penises (36% to 72%) and people with
15 cervixes (29% to 77%)⁵; and
16

17 Whereas, The nine-valent HPV vaccination is efficacious against HPV strains known to cause
18 anogenital warts, cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancers^{1,8}; and
19

20 Whereas, HPV vaccination programs in the United States have been expanded beyond female-
21 only programs to prevent HPV infection in all people⁶; and
22

23 Whereas, HPV vaccination is now FDA approved up to 46 years of age for all people, and is
24 recommended routinely for individuals aged 11-26 and may be recommended in 27-45 year-
25 olds after discussion with their clinician⁹; and
26

27 Whereas, Carceral facilities have limited history of providing HPV vaccinations, while
28 incarcerated individuals have low self-reported vaccination rates compared to the non-
29 incarcerated population^{10,11}; and
30

31 Whereas, Most incarcerated women between 18-26 years of age have not received HPV
32 immunization but would be willing to if offered¹¹; and
33

34 Whereas, People with criminal-legal histories are five times more likely to develop cervical
35 cancer in their lifetimes than the general population¹⁰; and
36

37 Whereas, The Federal Bureau of Prisons' Clinical Guidelines support routine cervical cancer
38 screening in carceral facilities as a means of cervical cancer prevention⁶; and

1 Whereas, Many carceral facilities under state and federal jurisdiction are not equipped to
2 provide basic gynecological medical care including gynecologic testing and procedures that
3 require specialized diagnostic equipment⁷; and
4

5 Whereas, Some carceral facility administrators and local health departments have
6 demonstrated an interest in providing HPV vaccination to people who are incarcerated^{12,13}; and
7

8 Whereas, Successful HPV vaccination programs have been introduced through collaborations
9 between carceral facilities and health departments^{12,13}; and
10

11 Whereas, Between 32% and 42% of formerly incarcerated individuals were medically insured
12 eight to ten months after release from their carceral facility¹⁴; and
13

14 Whereas, Uninsured and underinsured individuals are unlikely to have access to routine and
15 preventive medical care, including HPV immunization and cervical dysplasia treatment¹⁵; and
16

17 Whereas, A 2019 analysis from the US National Health Interview Survey guideline-concordant
18 cervical cancer screening showed disparities in cervical cancer screening by race, sexual
19 orientation, and rural residency¹⁶; and
20

21 Whereas, These disparities resulted in a lack of timely diagnosis and treatment for cervical pre-
22 cancers, leading to worse outcomes and disparities in mortality from cervical cancer^{17,18}; and
23

24 Whereas, Black women had a 19% increase in mortality risk compared to white women despite
25 controlling for age, stage, histology, and treatment¹⁷; and
26

27 Whereas, Barriers to screening include personal and structural barriers such as distrust in the
28 healthcare system, transportation, cost, time off work, and lack of access to facilities equipped
29 for cervical cancer screening^{17,18}; and
30

31 Whereas, Screening for HPV commonly consists of so-called “primary screening” for high risk
32 HPV (hrHPV) DNA in samples from a patient’s cervix using polymerase chain reaction (PCR),
33 and cytology wherein cervical samples are microscopically examined for presence of dysplasia
34 or neoplasia¹⁹; and
35

36 Whereas, Co-testing refers to screening with both primary screening and cytology¹⁹; and
37

38 Whereas, The use of a liquid-based, thin layer preparation technique for HPV cytology over
39 conventional preparation techniques allows for dual testing of HPV to gather further information
40 about cervical cancer risk²⁰; and
41

42 Whereas, Self-sampling is a type of primary screening where patients collect a vaginal sample
43 using various collection methods including tampon, brush, swag, lavage, or vaginal patch either
44 at home or at a clinic and then send those samples out to a third party for analysis¹⁰; and
45

46 Whereas, Self-sampling for HPV screening is not currently approved by the US Food and Drug
47 Administration (FDA)²¹; and
48

49 Whereas, In a systematic review of over 40 studies in the literature, a recent meta-analysis
50 found that pooled estimated sensitivity measuring cervical intraepithelial neoplasia (CIN) 2+ of
51 primary HPV testing, conventional cytology testing alone, or liquid-based cytology alone was

89.9%, 62.5%, and 72.9%, respectively, while the pooled specificity of the tests were 89.9%, 96.6%, and 90.3%, respectively²²; and

Whereas, The same study found that for detection of higher-grade CIN 3+, a comparison of primary testing compared to conventional cytology found a relative sensitivity of 1.46 (95% CI: 1.12 to 1.91) and a relative specificity of 0.95 (95% CI, 0.93 to 0.97), while comparison of primary hrHPV testing to liquid-based cytology in measuring CIN 3+ was found to have a relative sensitivity of 1.17 (95% CI, 1.07 to 1.28) and a relative specificity of 0.96 (95% CI: 0.95 to 0.97)²²; and

Whereas, In a meta-analysis of 36 studies, HPV testing on self-samples had a pooled sensitivity of 76% (85%, CI 69-82) for CIN 2+ and 84% (95% CI, 72-92) for CIN 3+, while the pooled specificity was 86% (95%, 83-89) and 87% (95%, 84-90) to exclude CIN 2+ and CIN 3+, respectively²³; and

Whereas, Self-testing was found to have lower sensitivity and specificity in a comparison of clinician-taken samples, with a ratio of 0.88 (95% CI, 0.85-0.91) for CIN 2+ and a ratio of 0.96 (95% CI, 0.95-0.97) for CIN 2+²³; and

Whereas, Studies have shown conflicting results regarding the sensitivity/specificity of self-sampling compared to clinician-collected samples for HPV testing^{21,23,24}; and

Whereas, Primary HPV testing has been shown in several analyses to cause an increase in detection of HPV and a decrease in cost burden to the healthcare system, and may be more cost-effective than co-testing²⁵⁻³⁰; and

Whereas, Emerging international evidence, particularly from the United Kingdom, suggests, that self-sampling for HPV may be a cost-effective approach for cervical cancer screening³¹⁻³³; and

Whereas, Compared to physician-administered testing, HPV self-sampling has been shown to increase equity in cervical cancer screening by offering a greater reach to ethnic minority women, sexual minority women, as well as women from lower socioeconomic backgrounds, therefore helping to reduce disparities in cervical cancer screening³⁴⁻³⁷; and

Whereas, Traditional Medicaid includes mandatory family planning service benefits for individuals of childbearing age, though it provides no formal definition for "family planning," leading to state-to-state variation in the services covered by this benefit³⁸; and

Whereas, While all states provide Medicaid coverage or public assistance programs for cervical cancer screening, the Affordable Care Act (ACA) expanded Medicaid and in so doing creating a new eligibility category which has federally-specified coverage requirements for family planning (including screening services), but these new requirements do not apply to states with a traditional Medicaid program only who have not expanded Medicaid³⁸; and

Whereas, For US citizens not eligible for Medicaid, the CDC also operates the National Breast and Cervical Cancer Early Detection Program (AKA the Early Detection Program) to provide cancer screening and diagnostic services to people who are low-income, uninsured, or underinsured³⁹; and

Whereas, Medicare covers all possible screening options currently recommended by the AAFP, ACS, ACOG, and USPSTF with the exception of primary HPV testing⁴⁰; and

Whereas, In their 2015 decision memo covering co-testing, the Center for Medicare and Medicaid Services (CMS) acknowledged that ongoing studies were evaluating HPV for primary, stand alone screening⁴¹; and

Whereas, AMA policy H-430.986 supports programs and staff training necessary to provide gynecologic care for incarcerated women and adolescent females; and

Whereas, AMA policy H-440.872 supports HPV vaccination and cervical cancer prevention worldwide and AMA Policy D-440.955 advocates for “the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations”; therefore be it

RESOLVED, That our American Medical Association amend Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition to read as follows:

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA:
 - (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,
 - (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
 - (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
6. Our AMA encourages collaboration with stakeholders to provide human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers. (Modify Current HOD Policy); and be it further

1 RESOLVED, That our AMA amend policy H-55.971, "Screening and
2 Treatment for Breast and Cervical Cancer Risk Reduction", by addition and
3 deletion to read as follows:

4
5 **Screening and Treatment for Breast and Cervical Cancer Risk**
6 **Reduction H-55.971**

7 1. Our AMA supports programs to screen all women individuals with
8 relevant anatomy for breast and cervical cancer and that
9 government funded programs be available for low income women
10 individuals; the development of public information and educational
11 programs with the goal of informing all women individuals with
12 relevant anatomy about routine cancer screening in order to reduce
13 their risk of dying from cancer; and increased funding for
14 comprehensive programs to screen low income women individuals
15 for breast and cervical cancer and to assure access to definitive
16 treatment.

17 2. Our AMA encourages state and local medical societies to monitor
18 local public health screening programs to ensure that they are linked
19 to treatment resources in the public or private sector.

20 3. Our AMA encourages efforts by the Centers for Medicare and
21 Medicaid Services to evaluate and review their current cervical
22 cancer screening policies in an effort to expand coverage for HPV
23 testing including but not limited to in-office primary HPV testing.
24 (Modify Current HOD Policy); and be it further
25

26 RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-
27 sampling in the United States to determine whether it can decrease health care disparities in
28 cervical cancer screening. (New HOD Policy)

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

Received: 3/27/23

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RELEVANT AMA POLICY

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

HPV Vaccine and Cervical Cancer Prevention Worldwide, H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
 3. Our AMA:
 - (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,
 - (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
 - (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
 4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
 5. Our AMA will study requiring HPV vaccination for school attendance.
- Citation: Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22; Modified: Res. 916, I-22;

Screening for HPV-Related Anal Cancer H-460.913

Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.

Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Insurance Coverage for HPV Vaccine D-440.955

Our AMA:

- (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
- (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
- (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Citation: Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16;

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing

between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.

10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22;

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation’s correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;

(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19;

Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles D-60.994

Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse.

Citation: Res. 401, A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971

1. Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment.

2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

Citation: (CCB/CLRPD Rep. 3, A-14)

Screening for HPV-Related Anal Cancer H-460.913

Our AMA supports: (1) continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer; (2) advocacy efforts to implement screening for anal cancer for high-risk populations; and (3) national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.

Citation: Res. 512, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 421, A-22;

Cancer and Health Care Disparities Among Minority Women D-55.997

Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.

Citation: Res. 509, A-08; Modified: CSAPH Rep. 01, A-18;

Quality of Pap Smear Analysis H-525.994

The AMA reaffirms its long-standing support of the Pap smear as an effective screening method for the detection of cervical cancer.

Citation: Res. 92, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.

2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.

3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.

4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in

receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

Citation: Alt. Res. 404, I-20; Appended: Res. 406, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-23)

Introduced by: Medical Student Section

Subject: Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972”
to Include Medical Professionals as a Party Who Can Petition the Court

Referred to: Reference Committee D

1 Whereas, Extreme Risk Protection Order (ERPO) laws and Red Flag laws stipulate that
2 parties such as law enforcement, family or household members, and/or intimate partners can
3 petition the court to temporarily remove firearms from a high risk individual through due
4 process¹; and
5

6 Whereas, An extreme risk individual is defined as an individual with severe mental illness
7 and/or who is at risk of harming themselves or others^{1,2}; and
8

9 Whereas, The Bipartisan Safer Communities Act passed by Congress in June 2022 allows
10 for Justice Assistance Grant (JAG) funding to be available to states who pass new ERPO
11 laws or improve existing ERPO laws³; and
12

13 Whereas, 19 states currently have ERPO/Red Flag laws; and in a White House meeting in
14 August 2022 representatives from Kentucky, Louisiana, Minnesota, New Hampshire, North
15 Carolina, Pennsylvania, and Texas shared plans for advancing new ERPO legislation
16 following the passage of the Bipartisan Safer Communities Act^{1,4}; and
17

18 Whereas, A study by Kivisto et al. (2018) showed that ERPO laws reduced suicide rates by
19 13.7% in Connecticut and 7.5% in Indiana; further Wintemute et al. (2019) evaluated 159
20 uses of California’s ERPO law and found 21 cases in which an ERPO was initiated after an
21 individual with access to firearms threatened a mass shooting, none of the threatened
22 shootings took place^{5,6}; and
23

24 Whereas, Only Hawaii, Maryland, Connecticut, New York and Washington, DC currently
25 include medical professionals as parties who can utilize ERPO laws, with Connecticut and
26 New York updating their ERPO laws to include this in June 2021 and June 2022
27 respectively^{1,7-10}; and
28

29 Whereas, In ERPO laws, “medical professionals” generally refers to licensed physicians,
30 physician assistants, advanced practice registered nurses, psychologists, counselors, and
31 social workers who have examined the individual^{9,11}; and
32

33 Whereas, In a Maryland study, surveyed physicians identified lack of knowledge about ERPO
34 laws as a barrier to physicians utilizing ERPO, and these same physicians asserted that this
35 barrier may be mitigated by increased training about ERPO laws¹²; and
36

37 Whereas, Since 2014, the ever-growing firearm epidemic has worsened, with the number of
38 mass shootings increasing from 273 per year in 2014 to 691 per year in 2021, the number of

1 deaths due to gun violence has increased from 12,418 people per year in 2014 to 19,411
2 people per year in 2020¹³; and

3
4 Whereas, The shooter in Buffalo New York in May 2022 was released without treatment, law
5 enforcement follow-up, or enactment of an ERPO following an evaluation by mental health
6 professionals, and following the shooting, New York updated its law to now include medical
7 professionals as a party able to file an ERPO^{7,14-16}; and

8
9 Whereas, Many states have mandatory or permissive Duty to Protect or Duty to Warn laws
10 for mental health professionals to report threats of imminent physical harm to other
11 persons^{17,18}; and

12
13 Whereas, Physicians, specifically those that treat persons at risk for suicide and intimate
14 partner violence, are highly trained to identify high-risk individuals based on symptoms,
15 behavioral patterns, and screening¹⁹⁻²²; and

16
17 Whereas, Medical professionals are encouraged to ask about firearm access during routine
18 patient visits which can help allow them to identify at risk individuals who may have access to
19 firearms²²; and

20
21 Whereas, HIPAA does not explicitly define firearm ownership as protected health information
22 (PHI), permitting disclosure in cases of public interest and benefit; and further in June 2021
23 the United States Department of Justice stated that disclosures of PHI are allowed in
24 compliance with ERPO laws when necessary to prevent imminent threats to the health and
25 safety of an individual and/or the public^{23,24}; and

26
27 Whereas, AMA policy H-145.972, Firearms and High Risk Individuals, describes the function
28 and process of ERPO/Red Flag laws but does not currently include medical professionals as
29 a party who can petition the court; and

30
31 Whereas, AMA policy H-145.976 supports creating state-specific guidance for physicians
32 about how to assess and act on risk of gun violence with patients within the scope of current
33 state law, but does not call for legislative change in those states; and

34
35 Whereas, AMA policy H-145.975 encourages physicians to work with families to reduce
36 patient access to lethal means when there is suicide risk but does not call for the passage of
37 laws to allow for physicians to act to reduce patient access to lethal means directly; therefore
38 be it

39
40 RESOLVED, That our American Medical Association work with relevant stakeholders to
41 develop state-specific training programs for medical professionals on how to use Extreme
42 Risk Protection Order/Red Flag Laws (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA work with relevant stakeholders to update medical curricula with
45 training surrounding how to approach conversations about Extreme Risk Protection
46 Order/Red Flag laws with patients and families (Directive to Take Action); and be it further

47
48 RESOLVED, That our AMA support amending policy "Firearms and High-Risk Individuals H-
49 145.972" by addition to read as follows:

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and state, federal, and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate stakeholders, contribute to the inception and development of such petitions; ~~(2)(3)~~ prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; ~~(3)(4)~~ expanding domestic violence restraining orders to include dating partners; ~~(4)(5)~~ requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; ~~(5)(6)~~ requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and ~~(6)(7)~~ efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

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

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.
4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17;
Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18;

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

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

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

Citation: (Res. 410, A-13)

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

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

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

Citation: Res. 214, I-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.

4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Mental Health Crisis D-345.972

1. Our AMA will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to:

a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;

b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;

c) Expand research into the disparities in youth suicide prevention;

d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;

e) Develop and support resources and programs that foster and strengthen healthy mental health development; and

f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.

2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.

Citation: Res. 425, A-22;

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

(1) Recognizes youth and young adult suicide as a serious health concern in the US;

(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;

(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;

(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;

(5) Encourages continued research to better understand suicide risk and effective prevention efforts in

youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;

- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
- (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
- (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
- (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

Senior Suicide H-25.992

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

HIPAA Law And Regulations D-190.989

Our AMA shall: (1) continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care; and (2) continue to work with the appropriate parties and trade groups to explore ways to help offset the costs associated with HIPAA compliance so as to reduce the fiscal burden on physicians.

Citation: Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Reaffirmation: A-22; Modified: BOT Rep. 9, A-22;

Protection of Health Care Providers from Unintended Legal Consequences of HIPAA D-190.983

Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.

Citation: (Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)

Confidentiality and Privacy Protections Ensuring Care Coordination and the Patient-Physician Relationship H-315.964

Our AMA supports: (1) the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings; and (2) the sharing of substance use

disorder patient records as required by the HIPAA Privacy Rule and as applies to state law for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.

Citation: Res. 220, A-19;

Police, Payer and Government Access to Patient Health Information D-315.992

Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.

Citation: Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmation: A-22;

Data on Firearm Deaths and Injuries H-145.984

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

Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-23)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee D

1 Whereas, The American Disabilities Act defines “disability” as “a physical or mental
2 impairment that substantially limits one or more major life activities of such individual, a
3 record of such an impairment, or being regarded as having such an impairment”¹; and
4

5 Whereas, Adults with disabilities experience health disparities related to social determinants
6 of health, as they are less likely to have jobs with competitive wages, more likely to live in
7 poverty, and more likely to experience mental health issues²; and
8

9 Whereas, People with disabilities have been disproportionately affected by the COVID-19
10 pandemic, in terms of both health outcomes and economically, with unemployment rates that
11 are nearly double the unemployment rates of nondisabled people³⁻⁵; and
12

13 Whereas, One in five people with disabilities, or approximately one million people in the US,
14 lost their job during the COVID-19 pandemic, compared to one in seven people in the general
15 population⁶; and
16

17 Whereas, Between 2019 and 2020, the percentage of people with disabilities who were
18 employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in
19 employment from 66.3% to 61.8%⁷; and
20

21 Whereas, Almost half of unemployed disabled individuals endure barriers to employment,
22 while less than 10% of individuals with disabilities have been able to use career assistance
23 programs⁸; and
24

25 Whereas, Existing literature demonstrates that employment training programs are highly
26 beneficial for students with disabilities to gain competitive employment, and many have
27 success rates of 100% employment for their students^{2,9}; and
28

29 Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state
30 grants through the Department of Labor for employment and training services for people with
31 disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in
32 2018^{10,11}; and
33

34 Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist
35 students with disabilities through a transition from school to employment¹⁰; and
36

37 Whereas, In order to sustain the services provided to the community, Centers for
38 Independent Living (CIL) programs developed by the WIOA independently raised six times
39 the federal appropriation of funds in 2019, contributing to a 27% increase in utilization of
40 resources to assist with transition from youth to adult life²; and

Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic, with community programs through WIOA reporting over 30% of employment service programming closed due to COVID-19¹²; and

Whereas, The Arc, an organization that trains and employs thousands of individuals with disabilities nationally, reported that employment programs have struggled during the COVID-19 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or furlough staff^{13,14}; and

Whereas, Section 188 of WIOA requires that employment services provide equal opportunities for individuals with disabilities to participate in services and receive appropriate accommodations; however, the COVID-19 pandemic has created disparities in receiving these accommodations¹⁵; and

Whereas, AMA Policy H-90.967 encourages government agencies and other organizations to provide psychosocial support for people with disabilities, but do not include employment benefits; and

Whereas, As employment and socioeconomic status are social determinants of health closely linked to health outcomes, increased resources for employment support programs would provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created for people with disabilities¹⁶; therefore be it

RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy)

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

Received: 3/31/23

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RELEVANT AMA POLICY

Support for Persons with Intellectual Disabilities H-90.967

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Citation: Res. 01, A-16;

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.

2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.

3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Citation: Res. 220, I-17;

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Citation: (Res. 705, A-13)

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

SSI Benefits for Children with Disabilities H-90.986

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.

Citation: (Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Support for Housing Modification Policies H-160.890

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Citation: Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-23)

Introduced by: Medical Student Section

Subject: Addressing Inequity in Onsite Wastewater Treatment

Referred to: Reference Committee D

1 Whereas, ‘Wastewater’ refers to any water that has been used for human activity, and is
2 most commonly produced through the everyday use of water by homes and businesses and
3 is contaminated with feces, urine, soaps, industrial wastes, and other organic matter, making
4 it unsuitable for reintroduction into the natural water supply¹; and

5
6 Whereas, In the United States, wastewater is often piped to centralized treatment facilities
7 where bulk products are strained, smaller pollutants are filtered or degraded, and biological
8 pollutants are disinfected, after which resultant water is fed into local watersheds²; and

9
10 Whereas, Exposure to inadequately treated wastewater may occur through occupational
11 exposure, breathing in wastewater-contaminated soil particles, or repeated ingestion of
12 wastewater-contaminated foods, and can lead to various illnesses including diarrheal
13 illnesses, helminth and trematode infections, and various skin disorders³⁻¹⁰; and

14
15 Whereas, Wastewater can also contain heavy metals like arsenic, mercury, lead, and
16 cadmium that can lead to diseases like cancer, cardiovascular disease, developmental
17 disorders, renal dysfunction, and osteoporosis, among others¹⁰⁻¹⁷; and

18
19 Whereas, There are clear disparities in access to adequate wastewater management
20 systems, with Tribal communities, communities of color, lower income communities, and rural
21 communities disproportionately having insufficient wastewater management systems¹⁸⁻²²; and

22
23 Whereas, In the United States, approximately 25% of residents do not have access to
24 underground sanitary sewers, which amounts to ~80 million people who must rely on onsite
25 wastewater treatment systems, otherwise known as septic tanks²³; and

26
27 Whereas, Because septic tanks are complex and expensive to install and require permitting
28 from the Environmental Protection Agency (EPA), houses and businesses in many poor rural
29 communities resort to using “straight pipe” sanitation systems wherein untreated toxic
30 wastewater is released directly into the environment²³⁻²⁶; and

31
32 Whereas, The prevalence of straight pipe sanitation systems means that hundreds of
33 thousands to millions of homes across the country are utilizing dangerous sewage systems
34 and could be releasing dangerous wastewater into nearby soil, lakes, or streams,
35 disproportionately in marginalized communities²⁷⁻²⁹; and

36
37 Whereas, Despite recent investment in wastewater management systems in the Bipartisan
38 Infrastructure Act of 2021, systemic underinvestment in wastewater management from
39 federal, state, and local governments has led to a projected deficit of \$1 trillion in funding by
40 2035^{30,31}; and

1 Whereas, Targeted research and investment by state governments into wastewater
2 treatment has yielded dividends, with efforts to implement improved agricultural and
3 stormwater management practices and build wastewater infrastructure from 2005 to 2013 in
4 North Carolina improved water quality in four stream segments by 2014, while price changes
5 and sewage system physical improvements such as pipe replacement and high-quality,
6 durable material usage led to a 12% decline in in-county sewage and a 41% decline in out-of-
7 county sewage in northern Georgia^{18,22,32}; and
8

9 Whereas, The Clean Water Act establishes the structure for regulating pollutant discharge
10 and maintaining water quality standards and requires that to discharge pollutants into a point
11 source, a person must obtain a permit through the National Pollutant Discharge Elimination
12 System (NPDES) and are subject to “a fine of not less than \$5,000 nor more than \$50,000
13 per day of violation, or by imprisonment for not more than three years, or both” for permit
14 violations³³; and
15

16 Whereas, Homes and businesses that use public “sanitary sewage” systems, including
17 straight pipe sanitation systems, do not need an NPDES permit and are regulated by their
18 local municipalities instead of by the EPA, indicating hundreds of thousands in the United
19 States use water treatment systems that are not regulated by the EPA and thus may be
20 releasing toxic wastewater into the environment^{24-26,33}; and
21

22 Whereas, Many state laws do not comprehensively address on-site wastewater management,
23 and those that do lack the flexible framework needed to support diverse communities³⁴; and
24

25 Whereas, Some states have provided local jurisdictions with additional regulatory power to
26 correct straight-pipe systems, such as a Minnesota law that allows municipalities to charge
27 \$500 per month to the owners of all straight-pipe systems not corrected after ten months of
28 non-compliance³⁵; and
29

30 Whereas, Some states have enacted programs to modernize and correct failed sewage
31 systems, but these programs are often underfunded, which the EPA has concluded leads to
32 continued contamination of local water systems^{36,37}; and
33

34 Whereas, When not paired with adequate funding to assist municipalities to transition to safer
35 wastewater management systems, punitive actions often fail to incentivize investments in
36 improved wastewater management, and instead place an undue burden on what are often
37 already struggling communities^{23,25}; and
38

39 Whereas, Innovative legislation like the Decentralized Wastewater Grant Act of 2020 which
40 established a grant program to allow low-income households to connect their homes to
41 existing wastewater infrastructures can provide communities affordable paths to make
42 necessary transitions to safer and more effective wastewater management systems, but are
43 insufficiently funded^{38,39}; therefore be it
44

45 RESOLVED, That our American Medical Association support that federal, state, and local
46 governments abate individual financial and criminal penalties for insufficient wastewater
47 management, especially those placed on underserved communities and American Indian
48 reservations due to environmental racism and socioeconomic disparities (New HOD Policy);
49 and be it further

- 1 RESOLVED, That our AMA support research by federal, state, and local governments to
2 develop strategies to reduce insufficient wastewater management and eliminate detrimental
3 health effects due to inadequate wastewater systems. (New HOD Policy)
4

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

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RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

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

Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-23)

Introduced by: Medical Student Section

Subject: School-to-Prison Pipeline

Referred to: Reference Committee D

1 Whereas, The School-to-Prison Pipeline is a term used to describe the biased application of
2 harsh disciplinary measures imposed on students which increases their likelihood of entering
3 the juvenile justice system^{1,2}; and
4

5 Whereas, The school-to-prison pipeline is a major public health issue that disproportionately
6 affects students of color, students from low-income household, and other vulnerable student
7 sub-groups, with Black students being suspended and expelled at a rate three times greater
8 than white students^{3,4,5}; and
9

10 Whereas, Male children who have moderate to severe food insecurity have an 11-fold increase
11 in suspension or expulsion, suggesting that the school-to-prison pipeline may be the result of
12 systematic health inequities rather than inherent behavioral issues with an individual child⁶; and
13

14 Whereas, Mixed-effects longitudinal models demonstrate that when controlling for
15 socioeconomic status, the odds of incarceration were 3.88 times greater for those who have
16 ever received a suspension as compared to those who have not⁷; and
17

18 Whereas, Zero tolerance policies historically stem from strict criminal punishments to tackle the
19 war on drugs in the 1980s and 1990s, but have now expanded into the education system with
20 intentions to reduce school disruptions^{1,2,8,9}; and
21

22 Whereas, The implementation of zero tolerances policies have resulted in an increased
23 presence of police in school, who may lack training in adolescent development, ultimately
24 leading to increases in the number of students arrested^{1,2,8,9}; and
25

26 Whereas, Students that are the victims of the discriminatory application of these policies are at
27 a greater risk for poor educational and health outcomes¹⁰⁻¹²; and
28

29 Whereas, Not addressing the underlying traumatic stress from these discriminatory practices
30 can perpetuate cycles of abuse, trauma, and incarceration, necessitating trauma-informed
31 physicians to mitigate these effects¹³⁻¹⁵; and
32

33 Whereas, The shift from a punitive system to a therapeutic, restorative, and individualized
34 approach has been recognized as the key towards ending the school-to-prison pipeline^{13,16-20};
35 and
36

37 Whereas, Implementing school-based restorative justice, which addresses student misconduct
38 through a positive and proactive systematic approach to underlying community issues, has
39 resulted in lower rates of absences and better academic outcomes^{13,17-19,21}; and

Whereas, Though our American Medical Association recently passed Student-Centered Approaches for Reforming School Disciplinary Policies (H-60.900), it does not fully address the causes and effects of the school-to-prison pipeline; therefore be it

RESOLVED, That our American Medical Association amend H-60.900 by addition to read as follows:

**Student-Centered Approaches for Reforming School Disciplinary Policies
H-60.900**

Our AMA supports:

- (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; ~~and~~
- (2) the consultation with school-based mental health professionals in the student discipline process;
- (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline;
- (4) transitions to restorative approaches that individually address students' medical, social, and educational needs;
- (5) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; and
- (6) limiting the presence of law enforcement patrolling in schools to only those settings and times where student and staff safety is at active risk. (Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
 2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
 3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
 4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
 5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
 6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.
- Citation: Alt. Res. 404, I-20; Appended: Res. 406, A-22;

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and (2) the consultation with school-based mental health professionals in the student discipline process.

Citation: Res. 008, A-22;

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Citation: Res. 404, A-17;

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22;

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21;

Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities H-430.988

- (1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of

these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20;

Update on Tuberculosis H-440.931

It is the policy of the AMA that: (1) All prison inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.

Citation: (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

Citation: CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16;

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19;

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System H-80.994

Our AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system.

Citation: Sub. Res. 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

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

Policing Reform H-65.954

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

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

AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16;

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.

Citation: CSAPH Rep. 01, A-20;

Use of the Choke and Sleeper Hold in Prisons H-430.998

The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.

Citation: (Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

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

Our AMA:

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

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

Police Chases and Chase-Related Injuries H-15.964

The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.

Citation: (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.

Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22;

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919

Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

Citation: BOT Rep. 18, A-19;

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

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

Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

School Resource Officer Qualifications and Training H-60.902

Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Citation: Res. 926, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-23)

Introduced by: Medical Student Section

Subject: Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

Referred to: Reference Committee D

1 Whereas, Out-of-hospital cardiac arrest (OHCA) results from a sudden circulatory collapse
2 and it is fatal without rapid cardiopulmonary resuscitation (CPR) and/or defibrillation¹; and
3

4 Whereas, Bystander CPR is performed by a person who is not within the organized
5 emergency-response system, and has been identified as a necessary intervention to improve
6 out-of-hospital cardiac arrest survival²; and
7

8 Whereas, Every minute of delay in CPR results in a 10% decrease in survival rate, with
9 OHCA being responsible for over 350,000 deaths per year in the United States with an
10 estimated overall survival of 10%³⁻⁵; and
11

12 Whereas, Key strategies to improve survival include early recognition and activation of the
13 Emergency Response System, early CPR, rapid defibrillation and an increase in rates of
14 bystander CPR^{5,6}; and
15

16 Whereas, The American Heart Association (AHA) and supporting research recognize that
17 women are less likely than men to receive CPR or AED application from a bystander, and
18 even emergency medical services (EMS) are less likely to resuscitate women⁷⁻⁹; and
19

20 Whereas, Although OHCA rates are similar across genders, women have overall lower
21 survival rates following CPR intervention or hospital discharge, which may be due to
22 bystander hesitation to remove clothing items^{8,10,11}; and
23

24 Whereas, Concerns regarding accusations of sexual harassment or inappropriate touching,
25 discomfort with breasts, and fears of injuring women are commonly cited by the public,
26 particularly men, as reasons why women are less likely to receive bystander CPR in
27 instances of OHCA, though delays in CPR intervention have been found to be more costly
28 than concerns related to performing CPR^{12,13}; and
29

30 Whereas, While factors impacting CPR quality, such as clothing removal and hand
31 placement, are impacted by the sex of the CPR mannequin utilized in training, 98.4% of
32 almost 900 online CPR instructional videos use a male patient or mannequin without female
33 anatomy, and none discussed female-specific barriers to CPR or defibrillation^{10,14}; and
34

35 Whereas, A study of the diversity of mannequins used across North and Latin America found
36 only 12% were non-white, 6% represented women, <1% represented a non-lean body
37 habitus, and 1% represented pregnant individuals¹⁵; and
38

39 Whereas, While CPR intervention during pregnancy does not differ from standard CPR
40 intervention other than manual left uterine displacement, studies show higher maternal

1 mortality rates due to hesitancy of performing CPR due to concerns of inflicting harm on the
2 patient¹⁶; and
3

4 Whereas, In a 2022 study performed in Australia, provider confidence for performing CPR on
5 individuals with physical disabilities or abnormal chest shape was significantly improved by a
6 supplemental training course¹⁷; and
7

8 Whereas, Though The International Liaison Committee on Resuscitation (ILCOR)
9 recommends a depth of between 5cm and 6cm for adult chest compressions, the optimal
10 chest compression depth recommended by ILCOR is unlikely to be sufficient when
11 performing CPR on a patient with obesity¹⁸⁻²⁰; and
12

13 Whereas, Patients with body mass index classifications of “obese” or “underweight” are
14 associated with higher rates of in-hospital mortality following out of hospital cardiac arrest²⁴;
15 and
16

17 Whereas, There are still health disparities in OHCA survival rates due to a lack of
18 competency in CPR and AED delivery for women, pregnant people, people with physical
19 disabilities, and people with obesity^{8,10,11,16,17,21}; and
20

21 Whereas, Options for increasing diversity of CPR mannequins include the utilization of
22 different skin colors, body types, and genders, or purchasing kits which can add breasts to a
23 “male” chested mannequin on which a bra can be attached¹⁵; and
24

25 Whereas, Current cost-effective methods to diversify primarily male CPR mannequins include
26 the Womanikin, an open-source design, or low-cost female accessory packs to add breasts
27 to existing mannequins, indicating that existing mannequins can be modified to address
28 current differences in OHCA survival following CPR intervention^{22,23}; and
29

30 Whereas, Options for CPR mannequins representing pregnant persons or persons with
31 physical disabilities are not widely available; and
32

33 Whereas, While 2020 American Heart Association guidelines for CPR and emergency
34 cardiovascular care states that it is reasonable to address barriers to bystander CPR for
35 female victims through educational training and public awareness efforts, it is clear additional
36 action needs to be taken in order to address the disparities noted in OHCA CPR
37 intervention²⁴; and
38

39 Whereas, Teaching materials used in American Heart Association Advanced Certified Life
40 Support (ACLS) training have previously been found to insufficiently reflect races and gender
41 at risk of requiring CPR²⁵; and
42

43 Whereas, AMA policy H-130.938 outlines guidelines for CPR training for the American public,
44 but it fails to address key healthcare inequities that exist in CPR education and intervention
45 among minority groups; therefore be it
46

47 RESOLVED, That our American Medical Association support use of diverse mannequins in
48 CPR and AED training, including, but not limited to, mannequins with breasts, mannequins
49 representing pregnant persons, mannequins representing persons with disabilities, and
50 mannequins of varying body sizes (New HOD Policy); and be it further

1 RESOLVED, That our AMA support the efforts of relevant stakeholders to develop diverse
 2 mannequins or modify current mannequins to reflect diverse patient populations, including,
 3 but not limited to, those representing pregnant persons or persons with physical disabilities
 4 (New HOD Policy); and be it further

5
 6 RESOLVED, That our AMA collaborate with relevant stakeholders to increase accessibility of
 7 CPR and AED training equipment representing diverse gender and body types in basic life
 8 support and advanced certified life support programs nationwide to ensure optimal
 9 competency for trainees of all education levels. (Directive to Taker Action)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
- (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945

Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.

Citation: CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 1, A-22;

E-8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
 - (b) Avoid stereotyping patients.
 - (c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
 - (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
 - (e) Encourage shared decision making.
 - (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
- The medical profession has an ethical responsibility to:
- (g) Help increase awareness of health care disparities.
 - (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
 - (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Inclusion of Women in Clinical Trials H-525.991

Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice.

Citation: Res. 183, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 05, A-16; Reaffirmed: Res. 909, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-23)

Introduced by: Medical Student Section

Subject: Formal Transitional Care Program for Children and Youth with Special Health Care Needs

Referred to: Reference Committee D

1 Whereas, Children and youth with special health care needs (CYSHCN) are those whose
2 health care needs are more complex and require specialized care for their physical,
3 behavioral, or emotional development beyond that required by children generally¹; and
4

5 Whereas, “Special health care needs” include any chronic conditions, such as cystic fibrosis,
6 cerebral palsy, congenital defects/conditions, type 1 diabetes and other similar health
7 conditions^{1,2}; and
8

9 Whereas, Almost 20% of children between 12 and 18 years of age have a special health care
10 need³; and
11

12 Whereas, People with disabilities are described as having an activity limitation or who use
13 assistance or perceive themselves as having a disability⁴; and
14

15 Whereas, Most of CYSHCN do not fall under the formal definition of “disabled”⁴; and
16

17 Whereas, 90% of CYSHCN, who previously faced high rates of childhood mortality, now
18 increasingly survive to adulthood due to advances in medicine and therefore need the
19 appropriate care they received as children and young adults⁵; and
20

21 Whereas, Pediatric practices do not routinely start planning for transition to adult care until
22 the patient is around 18 years of age, and many pediatric practices do not have the available
23 policies, plans, or educational materials for a proper transition⁶; and
24

25 Whereas, Adult clinicians often do not have the specific infrastructure, education, and training
26 to care for young adults with pediatric-onset conditions⁷; and
27

28 Whereas, Research demonstrates that CYSHCN currently are inadequately supported during
29 the transition from pediatric to adult health care⁶⁻⁹; and
30

31 Whereas, Transitioning from pediatric to adult services, particularly for CYSHCN, is
32 associated with decreased medication adherence, decreased patient engagement, increased
33 avoidable hospitalization, and other health risks like permanent end-organ damage and even
34 early death^{8, 10}; and
35

36 Whereas, The transition to adult services occurs during a developmental period marked by
37 increased risky behavior, emphasizing the need for stability and clear planning to promote
38 good outcomes and continued treatment adherence¹¹; and

Whereas, The ability of pediatricians and adult clinicians to communicate effectively during the transition to adult care results in better health outcomes for the individual¹²; and

Whereas, The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have released and reaffirmed a consensus statement supporting high-quality, planned transitions of care for all youth, especially CYSHCN¹³; and

Whereas, The American Academy of Pediatrics has published a clinical report that establishes an algorithm and set of guidelines (the “Transitional Clinical Report and Algorithm”) to support the transition from adolescence to adulthood in the clinical home¹³; and

Whereas, After nearly 10 years of effort and research since the Transitional Clinical Report and Algorithm was published, some effective models of transition systems were made by reputable organizations, like National Standards for CYSHCN, but none have been nationally established^{13,14}; and

Whereas, Current AMA policy encourages physicians to establish transitional care programs for children with disabilities (H-60.974), but existing language is not inclusive of all children with special health care needs¹⁶; therefore be it

RESOLVED, That our American Medical Association amend policy H-60.974, *Children and Youth with Disabilities*, by addition and deletion to read as follows, to strengthen our AMA policy and to include a population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

Children and Youth with Disabilities and with Special Healthcare Need H-60.974

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special healthcare needs (CYSHCN);

(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;

(3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;

(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;

(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, and CYSHCN, and their families to plan and make the transition to the adult medical care system;

(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and

(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations. (Modify Current HOD Policy)

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

Received: 43/23

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RELEVANT AMA POLICY

Children and Youth With Disabilities H-60.974

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;

(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;

(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;

(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;

(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;

(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and

(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

Citation: CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942

(1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.

(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:

(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.

(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.

(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and

functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19;

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in

identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;

(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-23)

Introduced by: Medical Student Section

Subject: Protecting Workers During Catastrophes

Referred to: Reference Committee D

1 Whereas, Catastrophes are defined as critical situations, including but not limited to natural
2 disasters such as hurricanes, droughts, earthquakes, as well as pandemics and acts of war,
3 that endanger the lives, health, and/or safety of the population^{1,2}; and
4

5 Whereas, Natural disasters have injured more than 2 million people in the last 10 years³; and
6

7 Whereas, From 1992 to 2006, an estimated 72 occupational deaths in the United States were
8 associated with hurricanes and 62 deaths were associated with non-hurricane floods⁴; and
9

10 Whereas, In 2019, nearly 3.5 million workers across all industries had work-related injuries
11 and illnesses that were reported by employers, with 2.8 million injuries and illnesses reported
12 in private industry⁵; and
13

14 Whereas, The 2019 Workplace Safety Index estimated the cost of the most disabling
15 workplace injuries to employers at more than \$55 billion a year⁶; and
16

17 Whereas, Research shows that work-related injuries and illnesses are largely underreported⁷⁻
18 ⁹; and
19

20 Whereas, Between 2014 to 2017, Occupational Safety and Health Administration (OSHA)
21 investigated only a quarter of reported occupational deaths¹⁰; and
22

23 Whereas, Marginalized essential workers may be at increased risk of illness or injury during a
24 critical situation such as a pandemic due to the failure of their employer to provide basic
25 health safety protections¹¹; and
26

27 Whereas, Employer failure of enforcing safety precautions was exemplified on December 10,
28 2021, when Amazon workers were not sent home before a tornado struck the warehouse,
29 despite hours of notice that severe weather was imminent, which ultimately killed six people
30 and injured many others¹²; and
31

32 Whereas, While the tragedy was multifactorial, some of the causes included Amazon telling
33 employees they could not leave, not telling workers to stay home, and failing to provide
34 workers with adequate emergency training in preparation for natural disasters such as
35 tornadoes¹³; and
36

37 Whereas, Amazon not only has a history of discouraging workers from taking time off during
38 national disasters, but also as having policies that prohibit workers from carrying their phones
39 on warehouse floors, requiring them to leave them in vehicles or employee lockers before
40 passing through security checks that included metal detectors¹⁴; and

1 Whereas, The OSHA requires most businesses to have Emergency Action Plans, which
2 include evacuation procedures, but US law leaves it up to employers to decide whether to
3 send employees home in response to natural disasters¹⁵; and
4

5 Whereas, Even when there are OSHA violations but no violation of law, the penalty for
6 companies are on the order of thousands of dollars, which is an insignificant cost to multi-
7 billion dollar companies¹⁶; and
8

9 Whereas, Many of the federal workplace standards for emergency response and
10 preparedness are decades out of date, are not comprehensive, and do not consider the
11 effects of climate change¹⁴; and
12

13 Whereas, OSHA does not have requirements for hospitals to develop evacuation plans in
14 case of a hurricane or other extreme weather event even though OSHA has been
15 “considering updating these standards” since at least 2014^{4,17}; and
16

17 Whereas, Employees who refused to drive to work when conditions were potentially unsafe
18 but their employers did not deem conditions to be dangerous are not federally protected,
19 including under the National Labor Relations Act⁴; and
20

21 Whereas, The Environmental Protection Agency has projected that climate change will
22 continue to disproportionately impact underserved communities, affecting many who cannot
23 afford the threat of losing their jobs¹⁸; and
24

25 Whereas, Many states do not provide full protection of workers against retaliation or threat of
26 retaliation during public health emergencies resulting in employees to attend their place of
27 employment out of fear of termination¹⁹; and
28

29 Whereas, Current AMA policy around catastrophe preparedness revolves around the medical
30 field response (D-130.972 and H-130.992) and the effects of climate change on natural
31 disasters and affected communities (D-130.966, H-135.938 and H-135.973); and
32

33 Whereas, Our American Medical Association has limited policy advocating for the safety of
34 workers mainly focusing on heat exposure, with existing resolutions stating that the AMA will
35 work with United States Department of Labor, OSHA, and other appropriate federal
36 stakeholders to develop and enforce evidence-based policies, guidelines, and protections
37 against heat injury for workers (D-135.967); and
38

39 Whereas, Current AMA policy: 1. Does not address its support for protecting all forms of
40 workers during various catastrophes, especially regarding workers who are penalized for
41 taking appropriate safety precautions, 2. Does not address working with stakeholders to
42 develop policies about workers traveling during catastrophes (D-135.967); and
43

44 Whereas, The Occupational Safety and Health (OSH) Act requires employers to ensure a
45 safe workplace as outlined by a “duty of care” to protect their employees against an
46 unreasonable risk of harm; however, this policy is applied variably as evidenced by how
47 many workplace injuries and deaths are caused by catastrophes^{4,20,21}; therefore be it

1 RESOLVED, That our American Medical Association advocate for legislation that creates
 2 federal standards of safety and protection of workers during natural or man-made
 3 catastrophes (Directive to Take Action); and be it further
 4

5 RESOLVED, That our AMA advocate that the United States Department of Labor, the
 6 Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders
 7 develop and enforce evidence-based policies, guidelines, and protections for workers at their
 8 place of employment and traveling to and from their place of employment during
 9 catastrophes. (Directive to Take Action)
 10

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

Received: 4/3/23

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RELEVANT AMA POLICY

All Hazards Disaster Preparedness and Response D-130.972

Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.

Citation: (Res. 426, A-06; Reaffirmed in lieu of Res. 218, I-15)

Proposed Crisis Relocation and Shelter Plans H-130.992

Patients must be treated regardless of how they are injured, and planning for treatment is an important part of good medicine. The AMA, therefore, is committed to working with the federal government to provide advice concerning development of sound medical planning for disasters and catastrophes of any and all magnitude.

Citation: (BOT Rep. I, I-82; Reaffirmed: Res. 34, A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Workers' Compensation H-365.981

Our AMA:

- (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
- (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
- (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
- (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
- (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
- (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
- (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
- (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
- (9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
- (10) will continue activities to develop a unified body of policy addressing the medical care issues

associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.

Citation: BOT Rep. X, A-93; Reaffirmed CMS Rep. 10, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: CMS na, A-17; Modified: CMS Rep. 01, A-17;

Advocating for Heat Exposure Protections for All Workers D-135.967

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.

Citation: Res. 502, I-21;

Development of a Federal Public Health Disaster Intervention Team H-130.942

1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups.
3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.

Citation: (BOT Rep. 3, A-07; Reaffirmed in lieu of Res. 218, I-15)

Fund for Public Health Emergency Response H-440.825

Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

Citation: Res. 420, A-16;

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full

integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification.

Citation: CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Bolstering Public Health Preparedness H-440.892

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.

Citation: Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19;

National Disaster Medical System H-130.979

The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency.

Citation: BOT Rep. Q, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

Farm-Related Injuries H-10.984

Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries;

(2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities;

(3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement;

(4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention;

(5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and

(6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience.

Citation: BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.

2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for

environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-23)

Introduced by: Medical Student Section

Subject: Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

Referred to: Reference Committee D

1 Whereas, In-install waste receptacles are a key feature in women's restrooms across the
2 United States and are widely recognized to be an important part of maintaining a sanitary
3 public facility¹²; and
4

5 Whereas, Lack of in-install waste receptacles is a significant barrier to managing menstruation
6 safely and accessibly for transgender and nonbinary people¹⁰; and
7

8 Whereas, Thirty-one percent of transgender people who are out in places of public
9 accommodation experience negative treatment due to their gender identity, and some
10 transmasculine people fear changing their menstrual products in a public restroom may out
11 them^{2,6,10}; and
12

13 Whereas, Some transmasculine individuals' physical appearance makes using the women's
14 restroom more dangerous than using the men's restroom in which menstrual product
15 receptacles are not universally available¹⁰; and
16

17 Whereas, Two-thirds of transmasculine people feel unsafe using the men's restroom during
18 menstruation¹; and
19

20 Whereas, Fifty-nine percent of transgender people sometimes avoid public restrooms for fear
21 of confrontation and discrimination⁴; and
22

23 Whereas, Twelve percent of transgender people are verbally harassed in public restrooms
24 and one percent of transgender people are physically or sexually assaulted in public
25 restrooms⁴; and
26

27 Whereas, Nearly one-third of trans people have limited the amount they ate or drank in order
28 to avoid using the restroom⁶; and
29

30 Whereas, Poor menstrual hygiene has been linked to an increase in urinary and reproductive
31 tract infections and a long-term increase in infertility, and eight percent of transgender people
32 fight a urinary tract infection, kidney infection, or another kidney-related problem due to
33 avoiding restrooms^{5,6}; and
34

35 Whereas, Menstruating trans and nonbinary people sometimes hide used menstrual products
36 in their sleeves or pockets to avoid disposing of them in public and risking outing
37 themselves¹⁰; and
38

39 Whereas, Menstruation, gendered association with menstruation, and use of menstrual
40 products are sources of distress for many transgender people; and being forced to carry a

1 used menstrual product is dehumanizing and worsens the gender dysphoria and social
2 stigma that contributes to the forty-one percent suicide attempt rate for transgender
3 people^{1,3,9,13}; and
4

5 Whereas, Non-lined sanitary receptacles yield ten times more microbial contamination than
6 other bathroom surfaces, and thus hiding used menstrual products in pockets poses a
7 serious health threat⁸; and
8

9 Whereas, Non-hygienic handling of used menstrual products poses a serious health risk of
10 Hepatitis B and C exposure; and thus the U.S. Occupational Safety and Health
11 Administration (OSHA) requires sanitary disposal bins be lined by a plastic or wax bag and
12 workers be provided gloves to prevent physical contact with used menstrual products^{7,8}; and
13

14 Whereas, Transgender people may still be accommodated within existing binary restrooms in
15 places that lack gender-neutral restrooms for such reasons as cost-prohibitiveness and
16 building structure¹⁰; and
17

18 Whereas, The American Medical Association has a history of advocating for people to use
19 the restroom that aligns with their gender identity¹¹; and
20

21 Whereas, AMA Policy H-65.964 advocates for policies that promote safe access to public
22 facilities, including restrooms, for transgender individuals, but does not include support for
23 interventions to make exclusionary binary restroom facilities more inclusive; therefore be it
24

25 RESOLVED, That our American Medical Association amend H-65.964 "Access to Basic
26 Human Services for Transgender Individuals" by addition and deletion to read as follows:
27

28 **Access to Basic Human Services for Transgender**
29 **Individuals H-65.964**

30 Our AMA (1) opposes policies preventing transgender individuals
31 from accessing basic human services and public facilities in line
32 with one's gender identity, including, but not limited to, the use of
33 restrooms; ~~and~~ (2) will advocate for the creation of policies that
34 promote social equality and safe access to basic human services
35 and public facilities for transgender individuals according to one's
36 gender identity, and (3) will advocate for the inclusion of waste
37 receptacles in all restrooms, including male designated stalls, for
38 safe and discreet disposal of used menstrual products by people
39 who menstruate. (Modify Current HOD Policy)
40

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

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RELEVANT AMA POLICY**Access to Basic Human Services for Transgender Individuals H-65.964**

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17;

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

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee D

1 Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical,
2 sexual, or psychological aggression committed by current or former partners, including but not
3 limited to stalking, sexual harassment, or sexual coercion^{1,2}; and
4

5 Whereas, 1 in 3 women and 1 in 4 men in the United States have experienced some form of
6 IPV, with increased rates of injury and rape reported in sexual and ethnic minority
7 populations^{3,4}; and
8

9 Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and
10 bisexual cisgender men report experiencing IPV compared to 35% and 29% of heterosexual
11 cisgender women and men, respectively⁵; and
12

13 Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4
14 times more frequently than individuals who do not self-identify with a sexual minority group⁵;
15 and
16

17 Whereas, National survey data from the Centers for Disease Control state that 53.8% of
18 multiracial women, 46% of American Indian women, and 43.7% of Black women have
19 experienced IPV, compared to 34.6% of non-Hispanic white women⁶; and
20

21 Whereas, Individuals who experience IPV are also more likely to become victims of other forms
22 of sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking^{7,8};
23 and
24

25 Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels
26 of societal stress, panic, and financial and emotional strain resulting from the COVID-19
27 pandemic⁹; and
28

29 Whereas, IPV has acute effects on physical and mental health, including injury, unintended
30 pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of
31 substance use disorders, and death by homicide^{10,11}; and
32

33 Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70%
34 increased risk for heart disease, and 80% increased risk for stroke¹²; and
35

36 Whereas, The healthcare-related costs due to IPV are estimated to be \$104,000 per female
37 victim and \$23,000 per male victim, totaling to \$5.8 billion annually^{13,14}; and

1 Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly \$3.6
2 trillion, which includes direct medical costs, lost productivity, the financing of criminal justice
3 proceedings, and replacement of lost or damaged property¹³; and
4

5 Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits,
6 long-term treatment of physical and emotional injuries, mental health conditions, and substance
7 use disorders, legal proceedings, childcare, and finding safety¹⁵; and
8

9 Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating
10 further reliance on the abuser for living expenses, childcare, and additional resources^{3,9,16}; and
11

12 Whereas, Close to 60% of IPV survivors report employment instability and job loss due to
13 violence-related reasons, including but not limited to stigma, workplace discrimination due to
14 negative physical and mental effects of IPV, propensity for recurrence of abuse, decreased
15 productivity, and frequent absences^{3,16}; and
16

17 Whereas, 67% of those who have experienced or are experiencing IPV state that interactions
18 with an abusive partner limited their ability to complete education or job training for future
19 career growth, resulting in over 17% leaving the workforce³; and
20

21 Whereas, On average, 83% of IPV survivors experience 7.2 days of lost productivity per month
22 at work, totaling in 8 million days each year, thereby decreasing their chances of earning raises
23 or promotions^{3,14}; and
24

25 Whereas, This loss in productivity and workforce attrition translates to an annual cost of over
26 \$9.3 billion to the United States¹⁴; and
27

28 Whereas, 55% of companies do not have, publicize, or provide training for a workplace
29 violence prevention policy offering protections in the event of IPV¹⁷; and
30

31 Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have
32 paid family and medical leave¹⁸; and
33

34 Whereas, The Family and Medical Leave Act of 1993 provides only eligible federal workers
35 unpaid leave for medical needs and does not include regulations for private-sector
36 employers¹⁹; and
37

38 Whereas, A lack of access to paid leave causes employers and workers to lose \$22.5 billion
39 annually in wages and profits²⁰; and
40

41 Whereas, Those who have experienced IPV remain more vulnerable to the detrimental
42 consequences of lost wages from limited opportunities for paid leave, due to inability to afford
43 daily costs of living and medical expenses^{18,20}; and
44

45 Whereas, 11 states, including the District of Columbia, have enacted legislation offering “safe
46 time provisions” that protect employees who are victims of IPV^{21,22}; and
47

48 Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context
49 of experienced violence, including but not limited to safe leave, protection from wrongful
50 termination, and legal assistance stipends in the event of court proceedings²¹; and

Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental, and social healing from trauma relating to any form of violence, particularly IPV, stalking, and sexual harassment by non-partners²²; and

Whereas, Violence-related safe leave is distinct from personal medical or family leave in that it includes extended time for ensuring personal and familial safety from threat of abuse, protection from premature or wrongful termination of employment, stipends for legal aid, and connection to social work or supportive agencies that facilitate physical, mental, and social recovery^{22,23}; and

Whereas, States, districts, and cities that have instituted paid or unpaid safe leave or paid family and medical leave policies inclusive of safe time provisions, including Sonoma, Seattle, New York, and Philadelphia, have not found negative economic effects, subsequent decreases in pay for other employees, or increases in unemployment^{18,21,22}; and

Whereas, Over \$1.1 billion could be saved in emergency department visits through paid safe leave since implementation increases job and financial security of those experiencing IPV while decreasing dependence on the abuser²⁰; and

Whereas, The implementation of paid safe leave decreased turnover of employees and healthcare costs for preventable conditions, simultaneously improving productivity and economic growth^{20,24}; and

Whereas, Survivors of IPV who had access to paid leave were better able to connect to family court, had increased job security, and retained greater protection against recurrence of any harassment or abuse by current, former, or non-partners^{1,25}; and

Whereas, Our AMA has policy (H-515.965) encouraging physicians to campaign against IPV and violence in all forms; and

Whereas, Though our AMA has individual policies on family, medical, and sick leave (H-420.979, H-440.823), it lacks policy supportive of providing adequate time for the physical, emotional, and psychiatric healing required following an experience of IPV or non-partner sexual violence; therefore be it

RESOLVED, That our American Medical Association recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers safe leave (New HOD Policy); and be it further

RESOLVED, That our AMA amend the existing policy H-420.979, "AMA Statement on Family and Medical Leave to promote inclusivity" by addition to read as follows:

AMA Statement on Family and Medical Leave, H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; ~~and~~ (4) leave for adoption or for foster care leading to adoption; and (5) safe leave provisions for those experiencing any instances of violence, including but not

1 limited to intimate partner violence, sexual violence or coercion, and stalking.

2 Such periods of leave may differ with respect to each of the foregoing
 3 classifications, and may vary with reasonable categories of employers. Such
 4 policies should encourage voluntary programs by employers and may provide for
 5 appropriate legislation (with or without financial assistance from government).
 6 Any legislative proposals will be reviewed through the Association's normal
 7 legislative process for appropriateness, taking into consideration all elements
 8 therein, including classifications of employees and employers, reasons for the
 9 leave, periods of leave recognized (whether paid or unpaid), obligations on return
 10 from leave, and other factors involved in order to achieve reasonable objectives
 11 recognizing the legitimate needs of employees and employers. (Modify Current
 12 HOD Policy)

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

Received: 4/3/23

The topic of this resolution is currently under study by the Council on Medical Education.

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

- (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
- (b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
- (c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
- (5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
- (6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
 - (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
 - (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
 - (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
 - (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
 - (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Citation: CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19;

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; ; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22;

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

Citation: CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19;

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

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

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

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
 8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
 9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical student to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
 10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
 11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
 12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
 13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
 14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
 15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
 16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
 17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
 18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
- Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-23)

Introduced by: Medical Student Section

Subject: Increased Access to HIV Treatment and Supportive Services in the Unstably
Housed and Homeless Population

Referred to: Reference Committee D

1 Whereas, Over three percent of people experiencing homelessness in the United States are
2 considered HIV--positive, compared to 1.8% of the stably housed population¹; and
3

4 Whereas, The San Francisco AIDS Foundation reported in 2017 that less than thirty-five
5 percent of HIV patients experiencing homelessness are considered to be virally suppressed,
6 and an observational study from 2014-2019 found that in Tennessee, patients who were
7 homeless were half as likely to achieve viral suppression compared to those who had a
8 permanent/stable home²⁻⁴; and
9

10 Whereas, According to an interventional study of HIV positive patients, lack of viral suppression
11 in homeless populations leads to a 63% increase in viral load and decreased CD4 count,
12 increased progression to AIDS, and increased HIV-related deaths⁵; and
13

14 Whereas, According to the Centers for Disease Control, viral suppression through the use of
15 antiretroviral therapy decreases an HIV-positive individual's viral load, improves immune
16 function against HIV, and prevents viral transmission to others through mechanisms such as
17 sexual exposure or sharing of syringes^{6,7}; and
18

19 Whereas, Increased viral suppression can reduce the transmission of HIV by more than 96%
20 while improving immune function and lowering the risk of AIDS- and non-AIDS-defining
21 complications¹; and
22

23 Whereas, Longitudinal studies identify lack of housing as a predictor of decreased continuity of
24 treatment among HIV-seropositive patients^{1,2}; and
25

26 Whereas, Lack of stable access to clean water, refrigeration, and proper nutrition can impair
27 adherence to antiretroviral treatments that require daily regimen^{8,9}; and
28

29 Whereas, The AIDS Drug Assistance Program (ADAP) provides FDA-approved medications
30 annually to half a million people with HIV who have limited or no health insurance^{10,11}; and
31

32 Whereas, According the ADAP directory, there are only thirty-two AIDS drug assistance
33 program locations nationwide, primarily in densely populated regions¹²; and
34

35 Whereas, Information about ADAP locations is accessible to the public via an online directory,
36 which may not be easily accessible to people experiencing homelessness due to lack of stable
37 internet access¹⁰⁻¹²; and

1 Whereas, Housing Opportunities for Persons With AIDS (HOPWA) is the only federal program
2 that provides housing opportunities for low income and homeless patients with HIV/AIDS¹²; and
3

4 Whereas, According to the HOPWA eligibility requirements, HOPWA considers itself a
5 competitive program¹⁴; and
6

7 Whereas, While individuals experiencing homelessness are able to apply for HOPWA grants,
8 the majority of grants are given to city or state governments with priority given to large
9 metropolitan areas¹⁴; and
10

11 Whereas, HOPWA's focus on increasing housing in metropolitan areas limits housing
12 opportunities for people experiencing homelessness in rural locations across the nation^{13,14}; and
13

14 Whereas, A 2016-2017 CDC analysis stated that Alabama, Arkansas, Kentucky, Mississippi,
15 Missouri, Oklahoma, and South Carolina have higher burdens of HIV cases in counties that are
16 considered rural¹⁵; and
17

18 Whereas, Stable housing provides HIV patients with increased access to care and consistency
19 of treatment regimens, increasing the likelihood of achieving viral suppression^{2,8,11,13}; and
20

21 Whereas, Existing AMA policy seeks to combat the HIV epidemic by encouraging the
22 development of educational interventions regarding HIV transmission (H-20.903), recognizing
23 the need for interventional measures that limit the transmission of HIV (H-20.922), supporting a
24 strategy to increase HIV testing, prophylaxis, and prevention (H-20.896), recognizing the urgent
25 need to reduce the transmission of HIV (H-20.907), and supporting increased financial care for
26 HIV patients (H-20.907), though no such policy exists to specifically address the need for
27 increased access to antiretroviral therapy and stable housing opportunities for people
28 experiencing homelessness; therefore be it
29

30 RESOLVED, That our American Medical Association support the development of regulations
31 and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs
32 (New HOD Policy); and be it further
33

34 RESOLVED, That our AMA recognize that stable housing promotes adherence to HIV treatment
35 (New HOD Policy); and be it further
36

37 RESOLVED, That our AMA amend current policy H-20.922, "HIV/AIDS as a Global Public
38 Health Priority" by addition and deletion to read as follows:
39

40 **HIV/AIDS as a Global Public Health Priority H-20.922**

41 In view of the urgent need to curtail the transmission of HIV infection in every
42 segment of the population, our AMA:

43 (1) Strongly urges, as a public health priority, that federal agencies (in
44 cooperation with medical and public health associations and state governments)
45 develop and implement effective programs and strategies for the prevention and
46 control of the HIV/AIDS epidemic;

47 (2) Supports adequate public and private funding for all aspects of the HIV/AIDS
48 epidemic, including research, education, ~~and~~ patient care, and access to stable
49 housing for the full spectrum of the disease. Public and private sector prevention
50 and care efforts should be proportionate to the best available statistics on HIV
51 incidence and prevalence rates;

- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

HIV/AIDS and Substance Abuse H-20.903

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Eradicating Homelessness H-160.903

Our AMA:

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

stakeholders related to the needs of housing-insecure individuals.

(13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
- (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
- (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
- (8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
- (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17;

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy, and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19;

Financing Care for HIV/AIDS Patients H-20.907

Our AMA:

- (1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;
- (2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;
- (3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient

care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;

(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;

(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;

(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;

(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;

(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.

Citation: (CSA Rep. 4, A-03; Reaffirmation I-11; Reaffirmation I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Health Equity in Federally Subsidized Housing

Referred to: Reference Committee D

1 Whereas, In the 1980s, the government passed legislation known as the Comprehensive
2 Environmental Response, Compensation and Liability Act of 1980 (CERCLA) to assist the
3 Environmental Protection Agency (EPA) in identifying and remediating the country's most
4 dangerously contaminated sites by setting aside a 'Superfund' of money¹; and

5
6 Whereas, The Superfund set aside by CERCLA went bankrupt in 2003 leaving cleanup and
7 remediation projects, with estimated costs of \$15-100 million, to be funded solely through tax
8 revenue²; and

9
10 Whereas, Supreme Court rulings starting in 2008 with *Burlington Northern v. the United*
11 *States* have severely reduced the financial liability of polluters, stalling funding for the
12 Superfund program²; and

13
14 Whereas, CERCLA defines hazardous substances as elements and compounds which
15 present an imminent and substantial danger to the public health and welfare of living
16 creatures and waterfronts¹; and

17
18 Whereas, Hazardous substances defined by CERCLA include but are not limited to lead,
19 hexavalent chromium, radium, and polychlorinated biphenyl chemicals (PCBs), are known
20 hazards to human health, causing intellectual and behavioral delays, anemia, lung disease,
21 inflammatory diseases, cancers, adverse effects on fertility, and prenatal development³⁻⁶; and

22
23 Whereas, The geographic areas identified through CERCLA contaminated with known
24 hazardous substances are commonly referred to as Superfund sites¹; and

25
26 Whereas, As of 2020, 73 million people (22% of the US population) lives within 3 miles of a
27 Superfund site⁷; and

28
29 Whereas, Proximity to environmental hazards increases the risk for lifelong chronic mental
30 and physical illnesses, including but not limited to cancer, congenital disabilities, and
31 developmental disabilities⁹; and

32
33 Whereas, In Texas, East Houston's Fifth Ward, a community with proximity to three
34 Superfund sites, there is a pediatric and adult cancer cluster with 43 percent of households
35 reporting a cancer diagnosis¹⁰; and

36
37 Whereas, According to an evaluation performed by the Office of Inspector General in 2019,
38 18,158 properties owned, subsidized, or managed by the Department of Housing and Urban
39 Development (HUD) are located within one mile of Superfund sites¹¹; and

1 Whereas, The majority of people living in federally subsidized housing belong to racial and
2 ethnic minority groups, subjecting these groups to a disproportionate amount of
3 environmental hazards exposure leading to inequitable health outcomes⁸; and
4

5 Whereas, Neither the EPA, the Department of Housing and Urban Development, states,
6 cities, nor realtors are obligated to disclose proximity to Superfund sites upon purchase or
7 lease agreement leaving citizens unaware of the health hazards they and their children face
8 until they are grappling with long-term consequences¹²; and
9

10 Whereas, Those who rent their home are significantly less likely than homeowners to know
11 that they live in close proximity to Superfund sites¹³; and
12

13 Whereas, There is often a disconnect between environmental protection organizations and
14 community members near superfund sites, with residents of nearby communities often
15 lacking adequate knowledge to assess the environmental hazards around them¹⁴; and
16

17 Whereas, A potential strategy for mitigating the lack of community knowledge of
18 environmental exposures is to put communication processes in place to anticipate the
19 potential for disconnect and seek regular feedback from community members¹⁴; and
20

21 Whereas, The Residential Lead-Based Paint Hazard Reduction Act of 1992 establishes
22 guidelines to “educate the public concerning the hazards and sources of lead-based paint
23 poisoning and steps to reduce and eliminate such hazards”, demonstrating that the
24 precedent for hazardous substance disclosure has already been established¹⁵; and
25

26 Whereas, The disclosures described in the Residential Lead-Based Paint Hazard Reduction
27 Act of 1992, which include the explicit disclosure of lead-based paint in the property, a
28 warning statement signed by both purchaser and seller, and a lead hazard information
29 packet, do not extend to other environmental hazards which may be present at each site¹⁵;
30 and
31

32 Whereas, The “right to know” principle applied to public health ethics allows for individual
33 autonomy in decision making with respect to awareness of environmental hazard exposure¹⁶;
34 and
35

36 Whereas, Disclosure of known environmental health risks would promote informed decision-
37 making supporting individual autonomy¹⁶; and
38

39 Whereas, Environmental health-related care includes but is not limited to blood hazardous
40 substance screening, fertility, and prenatal testing, pediatric cognitive and behavioral delays
41 screening, and prescriptions for heavy metal chelating drugs^{3-5,9}; and
42

43 Whereas, Planning and execution of a Superfund site cleanup may take years to decades as
44 evidenced by the over 1,800 Superfund sites, as of January 4, 2022, that have been marked
45 for clean-up for decades without completed remediation^{12,17}; and
46

47 Whereas, Communities residing on or near Superfund sites may have to wait years even
48 after a clean-up project has been initiated for the toxin levels in their environment to reach
49 levels acceptable for residential use¹⁷; and

1 Whereas, Although the EPA and community organizations work to remediate the Superfund
2 sites fully, the EPA admits some sites may never reach environmental toxin levels safe for
3 residential use¹⁸; and
4

5 Whereas, Under CERCLA, the EPA maintains the right to establish Alternate Concentration
6 Limits (CLs) for use in Superfund cleanups that may fall below the standards of widely used
7 pollutant limits¹⁸; and
8

9 Whereas, The EPA maintains the right to waive violations of other state and federal
10 regulations on toxin levels due to “technical infeasibility” in order to approve a Superfund
11 cleanup¹⁸; and
12

13 Whereas, The current HUD-EPA agreement only requests yearly status reports on
14 contaminant levels and environmental indicators at active Superfund sites, subject to the
15 availability of the agency’s funding and manpower, and EPA guidelines suggest no follow-up
16 or follow-up monitoring only every five years at deleted Superfund sites^{12,19}; and
17

18 Whereas, Environmental justice is defined as the principle that all people and communities
19 regardless of race, color, national origin, or income, are entitled to equal protection by
20 environmental and public health laws and regulations, while environmental injustice
21 describes environmental laws, regulations and policies that overly affect a group of people
22 resulting in greater exposure to environmental hazards²⁰; and
23

24 Whereas, Environmental racism refers to a type of environmental injustice in which the racial
25 and ethnic contexts of environmental regulations and policies, exposures, support structures,
26 and health outcomes cause inequitable environmental hazards for some racial groups^{21,22};
27 and
28

29 Whereas, Low-income and minoritized communities are burdened by environmental injustice
30 in that they reside in areas with higher environmental exposures, reduced preventive
31 measures, and limited medical intervention, further exacerbating health outcome disparities<sup>23-
32 27</sup>; and
33

34 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,
35 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial
36 segregation, exposed Black communities to environmental pollutants and targeting for
37 construction of toxin-releasing facilities, isolated them from essential health resources such
38 as healthy food options, hospitals, and green spaces, and permitted health inequities to
39 concentrate in disadvantaged low-income neighborhoods²⁸⁻³²; and
40

41 Whereas, The environmental justice and fair housing collaboration between the
42 Environmental Protection Agency (EPA) and U.S. Department of Housing and Urban
43 Development (HUD) remains inadequate due to insufficient action to provide non-
44 discriminatory and affordable housing units in locations without risk of environmental health
45 exposures³³; and
46

47 Whereas, A combination of inequitable land-use policies, lack of environmental regulation
48 and enforcement, and market forces in petrochemical and heavy metal industries have
49 contributed to the perpetuation of poverty and worse health outcomes in minoritized
50 populations³⁴; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease³⁵⁻⁴⁴; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations⁴⁵⁻⁴⁷; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes⁴⁸⁻⁵¹; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers⁵²⁻⁵⁹; and

Whereas, Our AMA policy H-135.996 addresses the existence of environmental pollution and supports research into its threat to human health; and

Whereas, Our AMA policy H-135.996 supports efforts to alert the American people to the dangers of general environmental pollution, however, it does not go far enough to ask for mandated disclosure to residents in known areas of environmental risk; and

Whereas, Our AMA policy H-135.996 does not directly address the need for expansion of federally funded health insurance coverage of services to specifically address the health risk associated with residing in or near polluted environments; and

Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat, and has pledged to work to combat the adverse health effects of racism (H-65.952); therefore be it

RESOLVED, That our American Medical Association acknowledge the potential adverse health impacts of living in close proximity to a Superfund site (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for mandated disclosure of Superfund site proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand construction of new public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend Policy D-135.997, "Research into the Environmental
2 Contributors to Disease," by addition and deletion to read as follows:

3
4 D-135.997 – ~~RESEARCH INTO THE ENVIRONMENTAL~~
5 CONTRIBUTORS TO DISEASE AND ADVOCATING FOR
6 ENVIRONMENTAL JUSTICE

7 Our AMA will (1) advocate for the greater public and private funding for
8 research into the environment causes of disease, and urge the National
9 Academy of Sciences to undertake an authoritative analysis of
10 environmental causes of disease; (2) ask the steering committee of the
11 Medicine and Public Health Initiative Coalition to consider environmental
12 contributors to disease and environmental racism as a priority public
13 health issues; (3) encourage federal, state, and local agencies to address
14 and remediate environmental injustice, environmental racism, and all
15 other environmental conditions that are adversely impacting health,
16 especially in marginalized communities; and ~~(34)~~ lobby Congress to
17 support ongoing initiatives that include reproductive health outcomes and
18 development particularly in minority populations in Environmental
19 Protection Agency Environmental Justice policies. (Modify Current HOD
20 Policy)
21

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

Received: 4/3/23

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RELEVANT AMA POLICY

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Modern Chemicals Policies H-135.942

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Citation: Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16; Reaffirmed in lieu of: Res. 505, A-19;

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

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

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-23)

Introduced by: Medical Student Section

Subject: New Policies to Respond to the Gun Violence Public Health Crisis

Referred to: Reference Committee D

1 Whereas, Gun violence is a major public health crisis in the United States with the Centers
2 for Disease Control and Prevention (CDC) most recently reporting 45,222 gun-related deaths
3 in 2020—a 14% increase from 2019, and the most on record at the time and¹⁻³; and
4

5 Whereas, The CDC reported that gun-related injuries were one of the five leading causes of
6 death for people aged 1 to 44 in the U.S. in 2020³⁻⁴; and
7

8 Whereas, A May 2022 letter in *The New England Journal of Medicine* based on 2020 CDC
9 data suggests that gun-related injuries have surpassed motor vehicle crashes to now
10 become the leading cause of death for children and young adults aged 1 to 19³⁻⁴; and
11

12 Whereas, According to 2020 CDC data, over 40% of gun-related deaths were homicides
13 (19,384 deaths, or 79% of all homicides) and over 50% of gun deaths were suicides (24,292
14 deaths, or 53% of all suicides), accounting for 124 deaths a day³; and
15

16 Whereas, The Gun Violence Archive, an independent data research group that tracks gun-
17 related incidents and defines a mass shooting using a statistical threshold as an event where
18 four or more people are shot, reported 692 mass shootings in 2021 and 610 in 2020⁵⁻⁶; and
19

20 Whereas, The Gun Violence Archive reported that 246 mass shootings took place in the first
21 five months of 2022⁶; and
22

23 Whereas, On May 24, 2022, 21 children and teachers were killed and 18 injured at Robb
24 Elementary School in Uvalde, Texas, the second deadliest school shooting on record, ten
25 years after 26 students and educators were killed in the Sandy Hook Elementary shooting⁷;
26 and
27

28 Whereas, On June 1, 2022, two physicians, a patient, and another healthcare worker were
29 killed and several injured in a mass shooting at the St. Francis Hospital in Tulsa, Oklahoma⁸;
30 and
31

32 Whereas, Advocacy to address the gun violence public health crisis is crucial to support the
33 AMA's goals of promoting racial justice and health equity, as CDC data shows that Black,
34 American Indian and Alaska Native, and Hispanic people are disproportionately affected by
35 gun homicides compared to white individuals⁹; and
36

37 Whereas, Multiple countries, including the United Kingdom, New Zealand, Norway, and
38 Australia, quickly introduced and have adopted successful national legislation to ban semi-
39 automatic and automatic weapons after just a single mass shooting¹⁰; and

1 Whereas, Approximately 20-25% of all handguns recovered at crime scenes were originally
2 purchased as part of a multiple sale, which is the purchase of more than one gun within 5
3 business days¹¹; and

4
5 Whereas, Handguns sold in multiple sales are up to 64% more likely to be used in crime
6 scenes than handguns sold individually¹²; and

7
8 Whereas, Many jurisdictions do not require background checks for the purchase of
9 ammunition; however, research predicts that background checks for ammunition purchases
10 would cut gun-related death rates by 81%¹³; and

11
12 Whereas, Waiting period laws that delay the purchase of firearms by a few days reduce gun
13 homicides by roughly 17%¹⁴; and

14
15 Whereas, States have different firearm inheritance laws where it may be easier in some
16 states for individuals to obtain a firearm, such as some states require the firearm to be
17 registered while other states don't require a permit to own a firearm^{15,16}; and

18
19 Whereas, In 2020, our AMA announced a partnership with West Side United to invest \$6
20 million in community infrastructure programs in Chicago's west side neighborhoods to
21 address issues relating to health inequities and economic vitality based on community needs,
22 including affordable housing, access to healthy foods, financing local business projects, and
23 supporting job creation efforts and educational programs¹⁷; and

24
25 Whereas, In the wake of the Pulse Orlando mass shooting in 2016, our AMA declared gun
26 violence as a public health crisis "requiring a comprehensive public health response and
27 solution" yet the number of gun deaths have only continued to rise (D-145.995)¹⁸; and

28
29 Whereas, Our AMA has adopted numerous policies to reduce gun trauma, injury and death,
30 including H-145.996, H-145.975, H-145.997, D-145.996, H-145.983, H-145.978, H-145.984,
31 H-145.979, H-145.985, H-145.990, H-145.992, H-145.993, H-145.999, H-515.971, and
32 145.001MSS, but as this crisis continues to escalate, further advocacy is needed; therefore
33 be it

34
35 RESOLVED, That our American Medical Association advocate for federal and state policies
36 that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all
37 federal and state requirements for background checks, waiting periods, and licensure
38 (Directive to Take Action); and be it further

39
40 RESOLVED, That our AMA advocate for federal and state policies to prevent "multiple sales"
41 of firearms, defined as the sale of multiple firearms to the same purchaser within five
42 business days (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA advocate for federal and state policies implementing background
45 checks for ammunition purchases. (Directive to Take Action)

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

Received: 4/5/23

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RELEVANT AMA POLICY**Gun Violence as a Public Health Crisis D-145.995**

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22;

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

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

Citation: (Res. 216, A-15)

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

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

Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze

firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms, (3) advocate for improvements to the quality, comparability, and timeliness of data on firearm injuries and deaths, and (4) advocate for repeal of laws which prohibit the release of firearm tracing data for research.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18; Reaffirmed: Res. 907, I-22; Appended: Res. 921, I-22;

Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery H-10.960

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physicians in policy advocacy and counseling patients so as to decrease the risk of morbidity and mortality.

Citation: CSAPH Rep. 3, I-21;

Less-Lethal Weapons and Crowd Control H-145.969

Our AMA: (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.

Citation: BOT Rep. 10, A-21; Reaffirmed: BOT Rep. 2, I-21;

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

Citation: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Citation: Res. 212, I-18; Modified: Res. 934, I-19;

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;

(5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21;

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

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

Citation: Res. 214, I-16;

Increasing Toy Gun Safety H-145.974

Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

Citation: (Res. 406, A-15)

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.

5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.

6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.

7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal

means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;

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

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

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

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

4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Citation: Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22;

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

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

Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Prevention of Unintentional Shooting Deaths Among Children H-145.979

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

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

Prevention of Ocular Injuries from BB and Air Guns H-145.982

The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.

Citation: Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16;

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Citation: Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15;
Appended: Res. 402, A-18;

Data on Firearm Deaths and Injuries H-145.984

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

Citation: Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13; Reaffirmed: Res. 907, I-22;

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
- (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
- (4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
- (5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18; Reaffirmation: I-22;

AMA Campaign to Reduce Firearm Deaths H-145.988

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

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

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

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

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

Prevention of Firearm Accidents in Children H-145.990

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

2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

Citation: Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18; Appended: Res. 923, I-22;

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18;

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18;

Restriction of Assault Weapons H-145.993

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

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

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Citation: Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18; Modified: Res. 907, I-22;

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Citation: Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.

4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18;

Guns in Hospitals H-215.977

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

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

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

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

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

E. Policies should undergo periodic reassessment and evaluation.

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

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

3. Our AMA will: (a) advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care; and (b) work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities.

Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16; Appended: Res. 404, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-23)

Introduced by: Senior Physicians Section

Subject: Treating Social Isolation and Loneliness as a Social Driver of Health

Referred to: Reference Committee D

1 Whereas, Social isolation and loneliness have been recognized as significant public health
2 concerns, with adverse impacts on physical and mental well-being, and quality of life¹; and
3

4 Whereas, Social isolation and loneliness are not only experienced by older adults but also affect
5 individuals across the lifespan, including young people, single parents, immigrants, and
6 individuals with disabilities; and
7

8 Whereas, Social isolation and loneliness are linked to a wide range of chronic diseases,
9 including cardiovascular disease, dementia, depression, and anxiety, and are associated with
10 increased morbidity and mortality; and
11

12 Whereas, Social isolation and loneliness can result from social and economic factors, including
13 poverty, inadequate housing, discrimination, and lack of access to healthcare and other
14 services, and can be exacerbated by emergencies and disasters such as pandemics²; and
15

16 Whereas, Social isolation and loneliness are shaped by structural factors that affect other social
17 determinants of health, including employment, education, and social policies that impact
18 housing, transportation, and community resources; therefore be it
19

20 RESOLVED, That our American Medical Association develop educational programs for
21 healthcare professionals and the lay public regarding the significance of social isolation and
22 loneliness to include promoting social connections through community-based programs and
23 encouraging social participation through volunteering, civic engagement, and community service
24 (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA promote enhancing access, including transportation, to health and
27 social services (Directive to Take Action); and be it further
28

29 RESOLVED, That our AMA encourage research to assess how forming networks earlier in life
30 helps to reduce loneliness and social isolation for adults, with a special focus on marginalized
31 populations and communities with limited access to resources (New HOD Policy); and be it
32 further
33

34 RESOLVED, That our AMA develop toolkits to help clinicians identify and address social
35 isolation and loneliness as a social driver of health (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA work collaboratively with state medical societies, community-based
38 organizations, social service agencies, and public health departments to promote social
39 connections and enhance social support for patients. (Directive to Take Action)

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

Received: 4/26/23

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RELEVANT AMA POLICY

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

1. Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
2. Our AMA: (a) will advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy; (b) adopts the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes; (c) will advocate for adequate standards and capabilities for electronic health records to effectively tag and protect sensitive data before it can be shared or reshared; and (d) supports ongoing monitoring and data collection regarding unintended harm to patients from sharing information on social determinants of health and social risk.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19; Appended: Res. 440, A-22;

Recognizing Loneliness as a Public Health Issue D-440.913

Our AMA: (1) will release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and (2) supports evidence-based efforts to combat loneliness.

Citation: Res. 432, A-22;

Senior Suicide H-25.992

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Citation: Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-23)

Introduced by: Medical Student Section

Subject: Increasing the Availability of Automated External Defibrillators

Referred to: Reference Committee D

1 Whereas, 18.8% of sudden cardiac arrests outside of the hospital occur in public spaces, and
2 70% of those sudden cardiac arrests in public spaces occur in residential complexes¹; and
3

4 Whereas, Laypersons witness 38.3% of cardiac arrest episodes that occur outside of the
5 hospital, and therefore they play a critical role in helping first responders address a cardiac
6 arrest¹; and
7

8 Whereas, Patients receiving an Automated External Defibrillator (AED) shock prior to
9 emergency medical service arrival resulted in 38% survival versus 9% survival in those who
10 only received cardiopulmonary resuscitation²; and
11

12 Whereas, When dispatchers instruct a bystander to locate an AED that is nearby, they are
13 seldom within obvious view, which can severely limit the application of the AED³; and
14

15 Whereas, The lack of AED accessibility is known as a major contributing factor to worse
16 health outcomes and is a barrier to increasing survival for out-of-hospital cardiac arrests
17 (OHCA)⁴; and
18

19 Whereas, One study in Howard County, Maryland reported a weak correlation between AED
20 location and witnessed OHCA sites, indicating that AEDs were not registered at sites with the
21 most OHCA occurrences⁵; and
22

23 Whereas, A study in Phoenix, Arizona found a weak correlation between sites where
24 incidents of OHCA took place and the number of AEDs available⁶; and
25

26 Whereas, AED-related disparate health outcomes present disproportionately in Black
27 neighborhoods, as shown by the fact that there was a positive correlation between cardiac
28 arrests in AED-unavailable public locations with higher numbers of Black residents⁷; and
29

30 Whereas, Black men and women in America have an incidence of out-of-hospital sudden
31 cardiac death at 2.8% and 2.3% compared to their White counterparts at 1.4% and 0.7%,
32 respectively⁸; and
33

34 Whereas, Currently our American Medical Association advocates for the widespread
35 placement of AED devices (H-130.938), but does not reference doing so in a targeted and
36 equitable manner that is necessary to speak to existing issues and disparities that a
37 generalized widespread distribution does not address; and
38

39 Whereas, Methodologies that take into account spatial and temporal data are needed to
40 determine placement of AEDs in areas that suffer from increased frequency of OHCA⁹; and

Whereas, Targeted placement of AEDs in areas with a high likelihood of sudden cardiac arrest events has been shown to be cost effective, decrease time to defibrillation, and increase odds of survival¹⁰⁻¹¹; and

Whereas, Optimizing the placement of AEDs in the public resulted in increased coverage of OHCA in areas with greater disparities similarly to the way that doubling the amount of AEDs would have done¹²; and

Whereas, Studies that utilized computational approaches to targeted placement of AEDs provided an additional modality that confirms the optimization of AED access, improves coverage and usage of AED devices, as well as increases survival in OHCA episodes¹³⁻¹⁴; therefore be it

RESOLVED, That our American Medical Association amend Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators," by addition to read as follows:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
- (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; ~~and~~
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim; and.

(13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist.
(Modify Current HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;

- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
 - (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
 - (8) supports the development and use of universal connectivity for all defibrillators;
 - (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
 - (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
 - (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
 - (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
- Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18;

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992

Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest.

Citation: Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System

Referred to: Reference Committee D

Whereas, Child, youth, and young adult suicide is the leading cause of death in this age group;
and

Whereas, Additional research has identified children, youths, and young adults within the welfare system to be at higher risk of suicide than other age/race matched peers; and

Whereas, Our American Medical Association has policy regarding research into higher risk individuals (H-60.937, *Youth and Young Adult Suicide in the United States*); therefore be it

RESOLVED, That our American Medical Association amend policy H-60.937, *Youth and Young Adult Suicide in the United States*, by addition and deletion to read as follows:

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- 1) Recognizes child, youth and young adult suicide as a serious health concern in the US;
- 2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- 3) Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide;
- 4) Encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- 5) Encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system;
- 6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults;

- 1 7) Supports research to identify evidence-based universal and targeted suicide
- 2 prevention programs for implementation in middle schools and high schools;
- 3 8) Will publicly call attention to the escalating crisis in children, youth and young
- 4 adult and adolescent mental health in this country in the wake of the Covid-19
- 5 pandemic;
- 6 9) Will advocate at the state and national level for policies to prioritize children's,
- 7 youth's, and young adult's mental, emotional, and behavioral health;
- 8 10) Will advocate for comprehensive system of care including prevention,
- 9 management, and crisis care to address mental and behavioral health needs for
- 10 infants, children, youth, and young adult and adolescents; and
- 11 11) Will advocate for a comprehensive approach to the child youth, and young adult
- 12 and adolescent mental and behavioral health crisis when such initiatives and
- 13 opportunities are consistent with AMA policy. (Modify Current HOD Policy)

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

Received: 5/2/23

RELEVANT AMA POLICY

Youth and Young Adult Suicide in the United States H-60.937

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
- (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
- (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
- (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16;

Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Foster Health Care

Referred to: Reference Committee D

1 Whereas, Our American Medical Association has established policy H-60.910, *Addressing*
2 *Healthcare Needs of Children in Foster Care*, delineating health care for children within the
3 foster care system; and
4

5 Whereas, Our understanding of the health care needs of children within the foster care system
6 has increased through evidence-based research; therefore be it
7

8 RESOLVED, That our American Medical Association amend policy H-60.910, *Addressing*
9 *Healthcare Needs of Children in Foster Care*, by addition and deletion to read as follows:
10

11 **Addressing Healthcare Needs of Children in Foster Care H-60.910**

12 Our AMA advocates for comprehensive, ~~and evidence-based, trauma-informed~~ care that
13 addresses the specific mental, developmental, and physical health care needs of children in
14 foster care. (Directive to Take Action)

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

Received: 5/2/23

RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Citation: Res. 907, I-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Prescribing Guided Physical Activity for Depression and Anxiety

Referred to: Reference Committee D

Whereas, Depression and anxiety are medical conditions with neurophysiological basis¹; and

Whereas, Depression and anxiety cause accelerated aging and put patients at risk for further chronic medical conditions²; and

Whereas, People with mental health conditions have lower life expectancy than the general population of 12–15 years, are at higher risk of developing chronic illnesses such as diabetes and heart disease, both of which are impacted by exercise^{6,7}; and

Whereas, Traditionally physical therapy is only recommended or covered by insurances for traditionally “medical” diagnoses, not for diagnoses such as depression and anxiety which also have a physical and medical component; and

Whereas, Due to increasing polypharmacy and patients experiencing side effects from psychotropic medications⁵ nonpharmacologic approaches to management of depression and anxiety should be studied and promoted; and

Whereas, A meta-analysis of 33 RCT showed that resistance exercise training significantly reduced depressive symptoms³; and

Whereas, Recent meta-analysis on structured exercise programs conclude that exercise has a moderate to large antidepressant effect^{8,9}; and

Whereas, A meta-analysis of six prospective studies involving 26,473 participants and found a significantly decreased risk of depression symptoms among participants with strong handgrip strength (RR=0.74)⁴; and

Whereas, Preventative health measures can not only help alleviate suffering and improve quality of life for our patients, they can also cost the healthcare system less money in the long run¹⁰; therefore be it

RESOLVED, That our American Medical Association study evidence of the efficacy of physical activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive symptoms. (Directive to Take Action)

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

Received: 5/2/23

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RELEVANT AMA POLICY**Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928**

1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Citation: Res. 515, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: National Emergency for Children

Referred to: Reference Committee D

1 Whereas, During March–October 2020, the proportion of mental health-related visits in
2 emergency departments increased by 24% among U.S. children aged 5–11 years and 31%
3 among adolescents aged 12–17 years, compared with 2019; and
4

5 Whereas, Visits for overall mental health conditions among all children and adolescents
6 accounted for a larger proportion of all pediatric visits during 2020, 2021, and January 2022
7 than during 2019, with variation by age group and mental health condition; and
8

9 Whereas, Suicide is the second leading cause of death for youth ages 10-18 in the United
10 States; and
11

12 Whereas, Suicide rates for American Indian or Alaska Native, Asian, Black, Hispanic, and
13 multiracial youth increased dramatically between 2018 and 2021 with the highest rate of
14 increase among non-Hispanic Black youth at 36.6%; and
15

16 Whereas, 20.1% of youth ages 12-17 had a major depressive episode in the past years,
17 compared to 15.7% of youth in 2019; and
18

19 Whereas, In 2021, 42% of high school students reported feeling persistently sad or hopeless
20 and 29% reported experiencing poor mental health; and
21

22 Whereas, Nearly half of all youth with mental health disorders do not receive treatment; and
23

24 Whereas, The American Academy of Child and Adolescent Psychiatry, the American Academy
25 of Pediatrics, and the Children's Hospital Association declared a National State of Emergency in
26 Children's Mental Health in 2021; therefore be it
27

28 RESOLVED, That our American Medical Association declare a national state of emergency in
29 children's mental health. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-23)

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

Subject: Reducing Sodium Intake to Improve Public Health

Referred to: Reference Committee D

1 Whereas, Sodium is an essential nutrient necessary for maintenance of health and whole-body
2 function and excess sodium is linked to adverse health outcomes, including increased blood
3 pressure. The primary contributors to dietary sodium consumption depend on the cultural
4 context and dietary habits of a population. Nine out of 10 U.S. men and women will develop
5 hypertension at some point in their lives¹; and
6

7 Whereas, The main source of sodium in our diet is salt, sodium can be found naturally in foods
8 such as milk, meat, and shellfish as well as in common condiments, such as soy sauce and
9 sodium glutamate. Sodium is often found in high amounts in processed foods. These foods are
10 often more affordable and available to the general public resulting in higher consumption of
11 sodium; and
12

13 Whereas, On average people consume 9-12 grams of salt per day, or around twice the
14 recommended maximum level of intake. Salt intake of less than 5 grams per day for adults
15 helps to reduce blood pressure and risk of cardiovascular disease, stroke, and coronary heart
16 attack. The principal benefit of lowering salt intake is a corresponding reduction in high blood
17 pressure. Researchers estimate that reducing the average daily sodium intake in the U.S. to
18 2,300 milligrams (about 1 teaspoon of salt) per day would prevent 11 million cases of
19 hypertension and would save \$18 billion in health care costs each year³. An estimated 2.5
20 million deaths could be prevented each year if global salt consumption were reduced to the
21 recommended level; and
22

23 Whereas, World Health Organization (WHO) Member States have agreed to reduce the global
24 population's intake of salt by a relative 30% by 2025. Reducing salt intake has been identified
25 as one of the most cost-effective measures countries can take to improve population health
26 outcomes. Key salt reduction measures will generate an extra year of healthy life for a cost that
27 falls below the average annual income or gross domestic product per person; and
28

29 Whereas, The U.S. Food & Drug Administration (FDA) released new voluntary guidance on
30 October 13, 2021, encouraging the food industry to gradually reduce sodium in commercially
31 processed, packaged, and prepared foods over the next two and a half years—with the aim of
32 helping Americans reduce their average levels of sodium from 3,400 to 3,000 mg/day; and
33

34 Whereas, In 2013, the World Health Assembly (WHA) agreed to global voluntary prevention
35 targets including a relative reduction in the intake of salt by 2025. The "Global Action Plan for
36 the Prevention and Control of Noncommunicable Diseases 2013-2020" gives guidance and a
37 menu of policy options for Member States, WHO and other UN agencies to achieve the targets;
38 and

Whereas, Some manufacturers have voluntarily agreed to cut back on sodium as part of New York City's National Salt Reduction Initiative⁶. The aim of this initiative is to guide a voluntary reduction of salt levels in packaged and restaurant foods, with the primary goal of cutting the salt in packaged and restaurant foods by 25% over five years – which would reduce the nation's salt intake by 20% and prevent thousands of deaths; and

Whereas, Finland and the United Kingdom have led successful sodium reduction efforts. In Finland, a government-led program of education, salt-labeling legislation, and pressure on the food industry has led to a 30 percent reduction in salt intake, from 12,000 milligrams a day to around 9,000 milligrams today⁷; therefore be it

RESOLVED, That our American Medical Association work with all relevant stakeholders to advocate and advise salt reduction through public outreach that may include, but not be limited to, policy changes, ad campaigns, educational programs, including those starting in schools, and food labeling (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back at the 2024 Annual Meeting the effectiveness and feasibility of salt reduction strategies with specific interventions such as:

1. Consumer awareness and empowerment of populations through social marketing and mobilization to raise awareness of salt alternatives and the need to reduce salt intake
2. Government policies, including appropriate fiscal policies and regulation, to ensure food manufacturers produce healthier affordable low-sodium foods and retailers make such products available
3. Integrating salt reduction strategies and alternatives into the training curriculum of food handlers
4. Removing opportunistic use of saltshakers
5. Introducing and regulating "High in Sodium" (or similar) front-of-pack product labels or prominent shelf labels
6. Automating targeted sodium dietary advice to people visiting health facilities
7. Advocating for people to limit their intake of products high in salt and advocating that they reduce the amount of salt used for cooking
8. Educating and providing a supportive environment for children to encourage early adoption of low salt diets
9. Reducing salt in food served by restaurants and catering outlets, and labelling the sodium content of this food. (Directive to Take Action)

Fiscal Note: Not yet determined.

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home

Referred to: Reference Committee D

Whereas, Our American Medical Association has established policy H-420.979, *AMA Statement on Family and Medical Leave*, regarding employment leave with reasonable job security and health benefit security; and

Whereas, Our AMA policy H-420.979 also includes leave for adoption or for foster child placement leading to adoption; and

Whereas, There are over 600,000 children in 2021 who were in the foster care system in our country; and

Whereas, Current research indicates that children who are removed from their homes and enter the foster care system have better outcomes if they are placed in a home environment as opposed to a residential setting; and

Whereas, There is a current shortage of adults who serve as foster parents for children in the foster care system; and

Whereas, Incorporating a new child into a foster home is a critical time in both the child's and foster parent's lives in order to develop a successful placement for both; and

Whereas, Protected leave from work as needed for foster placement, not necessarily leading to adoption only, would provide for improved successful placement; therefore be it

RESOLVED, That our American Medical Association amend H-420.979, *AMA Statement on Family and Medical Leave*, by addition and deletion to read as follows:

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- 1) Medical leave for the employee, including pregnancy, abortion, and stillbirth;
- 2) Maternity leave for the employee-mother;
- 3) Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- 4) Leave for adoption or for foster placement of a child in foster care in the home leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies

1 should encourage voluntary programs by employers and may provide for appropriate
2 legislation (with or without financial assistance from government). Any legislative
3 proposals will be reviewed through the Association's normal legislative process for
4 appropriateness, taking into consideration all elements therein, including
5 classifications of employees and employers, reasons for the leave, periods of leave
6 recognized (whether paid or unpaid), obligations on return from leave, and other
7 factors involved in order to achieve reasonable objectives recognizing the legitimate
8 needs of employees and employers. (Modify Current HOD Policy)

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

Received: 5/2/23

RELEVANT AMA POLICY

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22;

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

1 Whereas, Police brutality and negative police interactions many times are products of structural
2 racism; and
3

4 Whereas, Black, Indigenous, and Hispanic/Latino individuals are significantly more likely to be
5 killed or injured by police than White individuals; and
6

7 Whereas, Being killed by police is the sixth leading cause of death for young Black men; and
8

9 Whereas, Both Black women and Indigenous women are about 1.5 times more likely to be killed
10 by police than White women; and
11

12 Whereas, Police surveillance, police stops, and verbal harassment can have large and
13 disproportionate public health impacts, even absent physical violence by police; and
14

15 Whereas, Policing has shown to have a detrimental effect on the mental, physical and economic
16 health of Black, Indigenous, Hispanic/Latino and other communities of color; and
17

18 Whereas, Systems need to be put in place to address the adverse health outcomes that are
19 occurring as a result of policing policies that are influenced by structural racism; and
20

21 Whereas, Given the recent public and media interest of deaths in custody, these deaths have
22 the potential to be publicly scrutinized not just for how the situation was handled by law
23 enforcement, but also for how the case was managed by the medical examiner, forensic
24 pathologist, or coroner; and
25

26 Whereas, "Death in custody" refer to those deaths in which the death happens while the
27 decedent is in either direct or indirect contact with law enforcement, whether during an initial
28 confrontation with law enforcement authorities, during the process of arrest, during transport to
29 a facility, or during incarceration; and
30

31 Whereas, Deaths in custody are complex issues that require medical examiners, forensic
32 pathologists, or coroners to be knowledgeable and deliberative about their diagnoses; and
33

34 Whereas, It is critical that medical examiners, forensic pathologists, or coroners manage
35 investigations/evaluations of deaths in custody using a consistent and uniform approach; and
36

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

Whereas, It is up to the discretion of the medical examiner, forensic pathologist, or coroner to communicate the circumstances of deaths in custody by using the “How Injury Occurred” and “Place of Death” sections contained within the death certificate, a practice that may miss many deaths if they are not correctly noted; and

Whereas, To assist in the accurate accounting of deaths in custody, an appropriate mechanism needs to be added to the U.S. Standard Certificate of Death to record deaths in custody; therefore be it

RESOLVED, That our American Medical Association advocate for research to be conducted that examines the public health consequences of negative police interactions (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a change to the U.S. Standard Certificate of Death to include a “check box” that would categorize deaths in custody and would create a new statistical grouping with explanations of the range of causes, manner and circumstances of death, within the spectrum of police custody, corrections custody, and legal custody. (Directive to Take Action)

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

Received: 5/3/23

REFERENCES

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6. U.S. Department of Justice, Bureau of Justice Assistance, Death in Custody Reporting Act: Reporting Guidance and Frequently Asked Questions, Version 3.0; revised March 2022; <https://bja.ojp.gov/funding/performance-measures/DCRA-Reporting-Guidance-FAQs.pdf>

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

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

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 determined¹; 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 1968¹; 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 18¹; 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 ideas²; 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 communities³; 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 more⁴⁻⁷; 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 indefinitely⁴⁻¹⁰; 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

Whereas, Criticism from gun lobbies, politicians, and Second Amendment advocates hamper control of guns and gun violence on social media⁴; and

Whereas, Social media can be used to provide useful content to combat gun violence^{9,11-13}; therefore be it

RESOLVED, That our American Medical Association call upon all social media sites and all others that allow posting of videos, photographs, and written online comments encouraging and glorifying the use of guns and gun violence to vigorously and aggressively remove such postings (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly recommend social media sites continuously update and monitor their algorithms in order to detect and eliminate any information that discusses and displays guns and gun violence in a way that encourages viewers to act violently (New HOD Policy); and be it further

RESOLVED, That our AMA work with social media sites to provide educational content on the use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating 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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2. AwesomeFin Tech. Social Media: Sharing Ideas & Thoughts. <https://www.awesomefintech.com/term/social-media/>. Accessed August 29, 2022.
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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

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

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

Whereas, Administrators without clinical experience in medicine, nursing, public health, or health service administration are regularly promoted to positions where they supervise physicians and other clinical staff; and

Whereas, Administrators direct the process and procedures of routine and acute clinical care as well as managing public health crises such as the COVID-19 pandemic; and

Whereas, Individuals who are confined to correctional facilities do not have a right to request health care outside of the correctional facilities; therefore be it

RESOLVED, That our American Medical Association support the following qualifications for the Director and Assistant Director of the Federal Bureau of Prisons positions and other administrators supervising physicians and other clinical staff within its facilities:

1. MD or DO, MBSS, degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting.
2. Knowledge of health disparities among Black, Indigenous, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
3. Knowledge of the health disparities among individuals who are involved with the criminal justice system (New HOD Policy); and be it further

RESOLVED, That our AMA initiate a public health campaign or appropriate effort to promote the highest quality of healthcare and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. (Directive to Take Action)

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

Received: 5/10/23

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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

Whereas, American Medical Association policy H-60.934, *Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media*, addresses “Protecting Children and Youth Who Use the Internet and Social Media”; and

Whereas, According to one report, “nearly 3 in 5 US teen girls felt persistently sad or hopeless in 2021 – the highest level reported over the past decade”¹; and

Whereas, In a recent health advisory, the American Psychological Association (APA) recommends that “3. in early adolescence (i.e., typically 10-14 years), adult monitoring is advised for most youths’ social media use...”²; and

Whereas, APA also recommends that “4. To reduce the risks of psychological harm, adolescents’ exposure to content on social media that depicts illegal or psychologically maladaptive behavior, including content that instructs or encourages youth to engage in health-risk behaviors, such as self-harm (e.g., cutting, suicide), harm to others, or those that encourage eating-disordered behavior (e.g., restrictive eating, purging, excessive exercise) should be minimized, reported, and removed; moreover, technology should not drive users to this content. ...”²; and

Whereas, APA also recommends that “5. To minimize psychological harm, adolescents’ exposure to “cyberhate” including online discrimination, prejudice, hate, or cyberbullying especially directed toward a marginalized group (e.g., racial, ethnic, gender, sexual, religious, ability status), or toward an individual because of their identity or allyship with a marginalized group should be minimized”²; and

Whereas, APA also recommends that “6. Adolescents should be routinely screened for signs of “problematic social media use” that can impair their ability to engage in daily roles and routines, and may present risk for more serious psychological harms over time”²; and

Whereas, The state of Utah recently passed social media regulations that (1) require age verification prior to opening a social media account, (2) require parental consent before minors in Utah may maintain or open a social media account, (3) require social media accounts for minors in Utah to: (a) not display advertising, (b) not collect, share, or use personal information from that account, (c) not target or suggest ads, accounts, or content, and (d) limit hours of access; and

Whereas, There are age limits for driver’s licenses, tobacco use, alcohol use, and renting 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

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 violence¹; 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 nationwide⁵; 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 communities⁶⁻¹⁹; 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 misconduct²⁰; 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 people²⁰; 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 protect²¹⁻²³; 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%

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

3
4 Whereas, Qualified immunity is a federal legal doctrine in the United States that protects law
5 enforcement officers from civil litigation, including in cases in which they use excessive force,
6 intended to protect officers who make mistakes in high-stress, high-paced situation^{22, 27}; and

7
8 Whereas, In 2009, the Supreme Court ruling *Pearson v. Callahan* allowed judges to ignore the
9 question of whether excessive force was used and decide only whether the officer's conduct
10 was "clearly established as unlawful" and violated "clearly established" rights, a requirement that
11 is hardly ever met in lower courts due to the need for the plaintiff to identify a previously decided
12 case involving the exact same "specific context" and "particular conduct"²⁸⁻²⁹; and

13
14 Whereas, Lawyers are highly disincentivized from taking on a case against law enforcement's
15 use of excessive force, since plaintiffs in cases dismissed on the basis of qualified immunity
16 cannot recover fees or be appropriately compensated²⁸⁻²⁹; and

17
18 Whereas, Despite good intentions, qualified immunity protects the majority of law enforcement
19 officers from ever going to trial even in cases of egregious excessive force and makes it
20 increasingly difficult for citizens to win these cases, to the extent that 12.9% of white people and
21 16.8% of Black people killed by police are unarmed, but only 4% of law enforcement officers
22 who kill people are ever charged of a crime and only 1% are ever convicted²⁸; and

23
24 Whereas, Cases that have been dropped due to qualified immunity include a mistaken identity
25 in which the victim was shot 17 times; an unarmed victim being smashed into a car for having a
26 cracked windshield; and a 14-year-old boy being shot after dropping a pellet gun and raising his
27 hands in the air, among many others²⁸; and

28
29 Whereas, While some argue qualified immunity is necessary to protect officers from the burden
30 of litigation, personal financial responsibilities, and potential bankruptcy, a study of more than 80
31 state and local law enforcement agencies across the country found that in instances of
32 misconduct, the municipality or union, rather than individual officers, almost always paid, and
33 another study of over 1,000 lawsuits against law enforcement officers found qualified immunity
34 is rarely applied early enough in proceedings to protect officers from civil discovery (only 0.6
35 percent of the cases)²⁹⁻³¹; and

36
37 Whereas, Qualified immunity has thus created a justice system that perpetuates violence as law
38 enforcement officers who commit brutality and harassment—and the governments that employ
39 them—have little incentive to improve their practices and follow the law given the lack of
40 consequences; and

41
42 Whereas, Since June 2020 both Colorado and Connecticut have passed legislation to eliminate
43 qualified immunity and federal legislation has been introduced into congress; therefore be it

44
45 RESOLVED, That our American Medical Association recognize the way we police our
46 communities is a social determinant of health (New HOD Policy); and be it further

47
48 RESOLVED, That our AMA advocate for the reform of qualified immunity and other measures
49 that shield law enforcement officers from consequences of misconduct to further address
50 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.