2023 AMA Medical Student Section (MSS) Annual Meeting
Chicago, IL
June 7-9

Policy Materials

Section resolutions

Resolution 001 – Establishment of a Standing Committee Task Force
Resolution 002 – Free, Individualized Therapy for Medical Students
Resolution 003 – Addressing Self-discharge Against Medical Advice
Resolution 004 – Amending D-90.990 “Evaluate Barriers to Medical Education for Trainees with Disabilities” to Reflect Updated Approaches and LCME COCA Requirements
Resolution 005 – Inclusive Language for Immigrants in Relevant Past and Future AMA Policies
Resolution 006 – Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
Resolution 007 – The Stigma Surrounding “Noncompliant” Language in Patient Charting
Resolution 008 – Opposing Pay-to-Stay Incarceration Fees
Resolution 009 – Treating Traumatic Injury Survivorship as a Chronic Condition
Resolution 010 – Addressing Overconsumption of Poor-Nutritional-Quality Foods
Resolution 011 – Protecting Access to Gender-Affirming Care
Resolution 012 – Access to Torture Documentation for Asylum Seekers
Resolution 013 – Wearable Devices to Protect High-Exposure Occupations
Resolution 014 – Strategies to Mitigate Child Abuse and Neglect

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Section reports

GC Report A – Sunset Report
GC Report B – Resolution Task Force 2023 Update
Delegate Report A – Status of Pending MSS-Authored Resolutions to the House of Delegates
IOPTEF Report – Internal Operating Procedures/Election Task Force Report
MSS CDA WIM CBH Report A - Condemnation of Non-Therapeutic Sterilization for Contraception of Women with Disabilities without Informed Patient Consent
MSS CEQM COLRP Report A - Expanding and Reclassifying Emergency Medical Services
MSS CME CGPH Report A - Advocating for the Inclusion of Weight Bias Training for Medical Students
MSS COLA LGBTQ Report A - Pharmacy Access to Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) & Post-Exposure Prophylaxis (PEP)
MSS COLA MIC Report A - IMG Exemptions from Immigration Caps on IMG-Specific Immigration categories for Green Cards and VISAs
MSS LGBTQ WIM CME Report A - Accuracy and Awareness for Sex Representation in Medical Textbooks
MSS MIC CEQM Report A - Immigration Status in Medicaid & CHIP MSS MIC CGPH Report A - Mental Health Reform in Prisons
MSS WIM COLA Report A - Improving Safety of Planned Home Births through Midwifery Licensing and Regulation

Informational reports

Delegate Report B – Policy Proceedings of the Interim 2022 House of Delegates Meeting

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 01
(A-23)

Introduced by: Ryan Englander, Section Delegate

Subject: Establishment of a Standing Committee Task Force

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Our AMA Medical Student Section (MSS) currently has 16 standing committees that are coordinated by the MSS Vice Chair; and

Whereas, The standing committees are an essential part of the Medical Student Section and were established to convene a group of experts on specific areas of content within our section; and

Whereas, There has been growing confusion surrounding the role these committees have in our MSS in relation to programming, advocacy, responsibilities at AMA meetings, and throughout the policy cycle; and

Whereas, There are a growing number of requests to expand standing committee roles, including writing self-generated reports and creating more advocacy content; and

Whereas, There is interest in creating a structure for MSS Standing Committees to collaborate with AMA Councils; and

Whereas, Section 7 of the current AMA-MSS Internal Operating Procedures (IOPs) states, “The MSS Standing Committees and Task Forces shall be appointed by the Governing Council and shall support the mission of the MSS as outlined in MSS Internal Operating Procedures.”; and

Whereas, Anticipated IOP changes will allow the MSS Assembly to vote on the creation of new standing committees; and

Whereas, Standing committee members and leadership have expressed concerns regarding the size of committees, membership selection process, leadership selection process, and how to ensure committed membership; and

Whereas, A report was commissioned by the AMA-MSS Assembly at I-05 outlining the creation, maintenance, and dissolution of standing and ad-hoc committees, but was never completed; and

Whereas, Over the years, AMA staff and Governing Councils have worked to determine how to best support standing committee endeavors; and

Whereas, An actionable task force will address these concerns, clarify the role of standing committees in our MSS, and create best practices and guidance to ensure lasting success; therefore be it

RESOLVED, Following the conclusion of the A-23 meeting, the AMA-MSS Governing Council will assemble a Standing Committee Task Force to evaluate and provide recommendations on structure and operations of our MSS Standing Committees; and be it further

RESOLVED, The Standing Committee Task Force will be chaired by the Vice Chair and include opportunities for input from standing committees; and be it further

RESOLVED, The Standing Committee Task Force will submit an update on their progress to the assembly at I-23, and a completed report with their findings at A-24.

Fiscal Note: Minimal

Date Received: 04/10/2023

RELEVANT AMA AND AMA-MSS POLICY

640.013MSS AMA-MSS Standing Committees
The AMA-MSS Governing Council will:
(1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees and report back at I-05;
(2) handle requests for funding from MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council's goals, 30 days in advance of the monetary need; and
(3) seek funding for two conference calls per committee per year.
MSS Rep F, A-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Reaffirmed: MSS GC Rep B, A-21

640.008MSS MSS Committee Reports
It is the policy of the AMA-MSS that the AMA-MSS Governing Council may suggest changes to committee reports but may not alter them without consultation with and agreement of the committee. Further, the Governing Council may include an addendum to the committee report, should a dissenting opinion exist, to distinguish the opinions of the Governing Council from those of the committee.
MSS Rep L, I-91, Adopted in lieu of MSS Res 44, A-91; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Reaffirmed: MSS GC Rep B, A-21

640.014MSS Regional Representation on MSS Committees
The AMA-MSS Governing Council will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees.
MSS Amended Sub Res 21, I-07; GC Rep C, A-10 Filed [640.016MSS]; Modified and Reaffirmed: MSS GC Rep C, I-12; Reaffirmed: MSS GC Report A, I-17

MSS Internal Operating Procedure 4.4.2 Vice Chair
The Vice Chair shall:
4.4.2.1. Preside at meetings of the Governing Council in the absence of the Chair or at the request of the Chair.
4.4.2.2. Assist the Chair in the performance of his or her duties.
4.4.2.3. Have the primary responsibility of coordinating the internal operations of the MSS, including but not limited to the MSS standing and ad-hoc committees.

MSS Internal Operating Procedure 7 MSS Standing Committees
The MSS Standing Committees and Task Forces shall be appointed by the Governing Council and shall support the mission of the MSS as outlined in MSS Internal Operating Procedures.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 02
(A-23)

Introduced by: Jude Luke, Afua Addo, Harsimran Makkad, Carson Hartlege, Justin May, University of Cincinnati of College of Medicine

Subject: Free, Individualized Therapy for Medical Students

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Medical students face significant stress, anxiety, and depression that can negatively impact their mental and emotional well-being[1-3]; and

Whereas, 55.9% of medical students in the United States experience burnout, with 58.2% also exhibiting symptoms of depression, both of which are significantly greater than the general population despite medical students entering training with similar rates of depression as their nonmedical peers[4,5]; and

Whereas, Longitudinal studies have shown that medical students' depressive symptoms increase by an average of 14% compared to their baseline before they began medical school[6]; and

Whereas, Medical students often receive inadequate mental health support, with less than 40% of graduating medical students reporting use of mental health services at any point in their training[7]; and

Whereas, The high stress environment of medical school and the stigma surrounding mental health can deter medical students from seeking help[8-10]; and

Whereas, The AMA recognizes the importance of physician well-being, and has adopted policies supporting the importance of self-care, physician resilience, and addressing burnout (D-310.968); and

Whereas, Patients are being negatively affected as physician burnout has been found to double the rates of patient safety incidents and professionalism complaints[11]; and

Whereas, Studies have shown that one-on-one therapy can be an effective way to improve mental health, reduce stress and anxiety, and increase overall well-being[12,13]; and

Whereas, Studies have shown that providing cognitive behavioral therapy, free of cost, provides significant benefit to the mental wellbeing of undergraduate and graduate students, including medical students[14-18]; and

Whereas, The AAMC 'Recommendations Regarding Health Services for Medical Students' advises that "schools should provide access to confidential counseling by mental health professionals for all students"[19]; and

Whereas, A pilot model of providing free, one-on-one therapy for medical students demonstrated a majority usage amongst medical students in their preclinical years[20]; therefore be it

RESOLVED, That our AMA will work with the Council on Medical Education to support options for medical schools to provide free, individualized therapy to medical students as a means to improve their mental and emotional well-being.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

Res. 915, I-15; Revised: CME Rep. 01, I-16

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the

concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22

295.137MSS Expansion of Student Health Services
AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center's hours to include weekend coverage.
MSS Rep D, I-05, AMA Res 309, A-06, Referred; CME Rep 6, A-07 Adopted [H-295.956]; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Reaffirmed: MSS GC Rep B, A-21

295.164MSS Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment
AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan.
MSS Res 3, I-11; Reaffirmed: MSS GC Report A, I-16; Reaffirmed: MSS GC Report A, I-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 03
(A-23)

Introduced by: Ally Wong, Benton Westbrook, The University of Texas Health Science Center at San Antonio

Subject: Addressing Self-discharge Against Medical Advice

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Self-discharge against medical advice (AMA) is associated with higher rates of morbidity, mortality, and readmission compared to non-AMA discharge[1,2]; and

Whereas, Readmissions after self-discharge AMA cost more than $800 million annually[1]; and

Whereas, Patients discharged AMA were more likely to be readmitted to a different hospital compared with non-AMA patients, which increases fragmentation of care, mortality, and worse outcomes[1,3]; and

Whereas, Reducing readmission rates can improve the quality of life of patients and the financial well-being of the healthcare system[4]; and

Whereas, Adherence to discharge best practices are inconsistent in AMA discharges, with only 31.3% of cases showing documentation of follow-up plans, 24.4% documenting medications prescribed, and 30.2% documenting informed consent[5,6]; and

Whereas, A signed AMA form alone is not enough to ensure legal protection for providers and document the capacity of patients, but proper documentation of patient capacity is present in only 37.1% of cases and documentation of discussion about risks is present in only 69% of cases in self-discharges AMA[5,6]; and

Whereas, Risk factors for self-discharge AMA include young age, male, low socioeconomic status, no health insurance, no primary care physician, homelessness, nicotine dependence, depression, opioid-related conditions, and polysubstance use[7,8]; and

Whereas, Financial burden for patients is the leading cause of self-discharge AMA, with other reasons being negative attitudes and stigmas against their past medical history, communication barriers, health literacy barriers, doctor's bedside manners, lack of coordination among healthcare providers, and general mistrust of the healthcare system [9,10,11], and

Whereas, healthcare systems and providers still have an ethical commitment to minimizing patient harm, despite the absence of liability due to a properly conducted self-discharge against medical advice process[12]; therefore be it

RESOLVED, That our AMA supports research and early identification of patients vulnerable to self-discharge against medical advice and promote interventions that ameliorate such disparities; and be it further

RESOLVED, That our AMA study the ethics of nonmaleficence, liability, and justice regarding discharge against medical advice.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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.
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

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.

e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.
CMS Rep. 07, I-16

1.1.8 Physician Responsibilities for Safe Patient Discharge
Physicians' primary ethical obligation to promote the well-being of individual patients encompasses an obligation to collaborate in a discharge plan that is safe for the patient. As advocates for their patients, physicians should resist any discharge requests that are likely to compromise a patient's safety. The discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations.
Physicians also have a long-standing obligation to be prudent stewards of the shared societal resources with which they are entrusted. That obligation may require physicians to balance advocating on behalf of an individual patient with recognizing the needs of other patients.
To facilitate a patient's safe discharge from an inpatient unit, physicians should:
1. Determine that the patient is medically stable and ready for discharge from the treating facility; and
2. Collaborate with those health care professionals and others who can facilitate a patient discharge to establish that a plan is in place for medically needed care that considers the patient's particular needs and preferences.
If a medically stable patient refuses discharge, physicians should support the patient's right to seek further review, including consultation with an ethics committee or other appropriate institutional resource.
AMA Principles of Medical Ethics: I,II,VIII; Issued: 2016

Discharge Summary Reform D-160.913
Our AMA will coordinate with interested stakeholders to develop a model discharge summary that: (1) is concise but informational; (2) promotes excellent and safe patient care; and (3) improves coordinated discharge planning.
Res. 716, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 04
(A-23)

Introduced by: Zainub Dhanani, Stanford University School of Medicine; Julio Avila, University of New Mexico School of Medicine; Madison Hoenle, University of Illinois College of Medicine Rockford; Travis Jackson, University of Missouri School of Medicine; Naosuke Yamaguchi, Rosalind Franklin University of Medicine and Science; Syeda Akila Ally, University of Illinois College of Medicine Chicago; Amanda Block, Burnett School of Medicine at TCU; Caitlin Aguirre, UTMB John Sealy School of Medicine; Maya Ramy, Texas A&M School of Medicine; Nora Newcomb, Jorden Barrow, University of South Florida, Morsani College of Medicine; Olivia Larner, University of South Carolina School of Medicine Greenville; Courtney Lubaczewski, University of South Carolina School of Medicine Greenville; Swara Sarvepalli, Central Michigan University College of Medicine; Erin DuRoss, Central Michigan University College of Medicine; Gloria McGur, Michigan State University College of Human Medicine; Valerie Bresier, Albany Medical College; Dean Kim, UConn School of Medicine; Krishna Channa, UConn School of Medicine; Kaitlyn Petitpas, UConn School of Medicine; Jessica Naredo Rojas, Tufts University School of Medicine; Michelle Klausner, New York Medical College

Subject: Amending D-90.990 “Evaluate Barriers to Medical Education for Trainees with Disabilities” to Reflect Updated Approaches and LCME/COCA Requirements

Sponsored by: Region 1, Region 2, Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A person with a disability is defined as someone who faces limitations as a result of “interactions between a health condition… and a range of environmental and personal factors”[1]; and

Whereas, Medical students with disabilities comprise 7.6% of allopathic and 4.27% of osteopathic medical school students[2-3]; and

Whereas, People with disabilities are recognized and protected by federal law as a minority group that experience prejudice and discrimination, termed ableism[4-17]; and

Whereas, Section 504 of the Rehabilitation Act mandates that “no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination” within federal funded institutions[13]; and

Whereas, Technical standards are required to comply by federal regulations, so the use of outdated ableist language creates barriers for students with disabilities[5,13,18-20]; and

Whereas, Undergraduate medical education technical standards are written documentation of nonacademic criteria required for admission, progression, and graduation[21-22]; and

Whereas, Technical standards were first required in 1979 after an Association of American Medical Colleges (AAMC) Special Advisory Panel wrote a 5-part framework that included: 1) intellectual and conceptual abilities; 2) behavioral and social attributes; 3) communication; 4) observation; and 5) motor capabilities[21,23-24 1]; and

Whereas, The Liaison Committee of Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) require that every medical school create and display technical standards for accreditation[20,25]; and

Whereas, The AAMC has provided further guidance outside of their 1979 report and the LCME has updated their 1979 framework by increasing the categories and including a stipulation of "with or without accommodations"; however, the LCME and COCA do not currently specify what is required in each category but require the updated framework[18,20,21,24-28]; and

Whereas, Despite academic and previous AMMC published guidance on developing more inclusive technical standards, many medical schools continue to use outdated and restrictive language, similar to the 1979 AAMC Special Advisory Report[18,24,29-30]; and

Whereas, Different approaches to the language of the technical standards include the organic, functional, and competency-based frameworks[21,29,31-32]; and

Whereas, The organic approach requires the full use of certain faculties, including but not limited to vision, hearing, and sensation, to carry out specific tasks with those faculties[19,21,29,32]; and

Whereas, The explicit language of the organic approach limits the implementation of accommodations because multiple approaches may not be deemed acceptable despite leading to the same outcome[19,21,29,32]; and

Whereas, Yale University School of Medicine's technical standard exemplifies the organic approach by stating that students "must have sufficient somatic sensation and the functional use of the senses of vision and hearing"[33]; and

Whereas, Albert Einstein College of Medicine's technical standard exemplifies the organic approach by stating that students must "perform cardiopulmonary resuscitation; administer intravenous medication; apply pressure so as to stop bleeding; clear obstructed airways; suture simple wounds; and to perform basic obstetric maneuvers"[34]; and

Whereas, Using the organic approach requires medical students to be able to become any type of doctor, or an undifferentiated graduate, even though with specialization most physicians will not continue to use every skill after medical school[21,29,35]; and

Whereas, The functional approach differs from the organic approach by emphasizing nonacademic learning objectives rather than the process used to complete the objective[21,29,31-32]; and

Whereas, The functional approach broadens a school's ability creatively use accommodations to complete each competency[21,29,31-32]; and

Whereas, The Ohio State University College of Medicine's technical standard exemplifies the functional approach by stating that students must "provide or direct general care and emergency treatment for patients and respond to emergency situations in a timely manner"[36]; and

Whereas, West Virginia University School of Medicine's technical standard represents the functional approach when stating "A candidate should be able to execute motor movements reasonably required to provide general care and emergency treatment to patients…In any case where a candidate's ability to complete and interpret physical findings because of motor skills is compromised, the candidate must demonstrate alternative means and/or abilities to retrieve these physical findings"[37]; and

Whereas, The newest approach is the competency-based approach which proposes using degree-specific competencies, such as AAMC Entrustable Professional Activities, to structure learner requirements without the need for broad technical standards categories[21,29]; and

Whereas, The AAMC Entrustable Professional Activities include: "1. Gather a history and perform a physical examination. 2. Prioritize a differential diagnosis following a clinical encounter. 3. Recommend and interpret common diagnostic and screening tests. 4. Enter and discuss orders and prescriptions. 5. Document a clinical encounter in the patient record. 6. Provide an oral presentation of a clinical encounter. 7. Form clinical questions and retrieve evidence to advance patient care. 8. Give or receive a patient handover to transition care responsibility. 9. Collaborate as a member of an interprofessional team. 10. Recognize a patient requiring urgent or emergent care and initiate evaluation and management. 11. Obtain informed consent for tests and/or procedures. 12. Perform general procedures of a physician. 13. Identify system failures and contribute to a culture of safety and improvement"[38]; and

Whereas, The competency-based approach allows for individualized decisions to be made regarding abilities for admission, retention, and graduation[21], and

Whereas, The University of Michigan's technical standard exemplifies the competency-based approach while using the LCME categories by stating "Critical skills…include the ability to observe and communicate, as well as to understand, integrate core knowledge and skills"[39]; and

Whereas, Emory University School of Medicine technical standard exemplifies the competency-based approach in their framework and in their language stating that students must "communicate effectively with the patient and the patient's family in order to obtain an adequate medical history"[40]; and

Whereas, Medical education disability researchers support the functional approach[18,29]; and

Whereas, The competency-based approach is the latest framework proposed by leading experts in the field[21,29]; and

Whereas, While the organic approaches emphasize the limitations associated with a person's disability, the functional framework and competency-based approach focus on the potential of students with disabilities and allow for greater flexibility in accommodations[18,19,21,29]; and

Whereas, Restrictive technical standards, like ones based off of the organic approach, lead to denial of reasonable accommodations and exclusion from training opportunities based on disability[18,19,21,29]; and

Whereas, The standards of accreditation for allopathic medical schools determined by the LCME explicitly include disability as a protected category subject to protections against discrimination, yet the LCME's and COCA's guides to the technical standards lack specific instruction about preventing the use of restrictive language that may lead to increased barriers and discrimination[18,20,21,25]; and

Whereas, AMA policies H-140.825 and D-90.990 exemplify our AMA's support for both accommodations and students with disabilities; and

Whereas, While AMA policy D-90.990 advocates for inclusive technical standards that focus on the abilities of students with disabilities, the language is not updated to include the latest approach proposed by experts in the field and does not include advocating to the appropriate bodies that enforces technical standards; therefore be it

RESOLVED, That our AMA amends by addition and deletion D-90.990 "Evaluate Barriers to Medical Education for Trainees with Disabilities" to read as follows:

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990

1. Our AMA urges that the Liaison Committee of Medical Education, Commission on Osteopathic College Accreditation, and other relevant stakeholders require all medical schools and graduate medical education (GME) institutions and programs to create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" ~~standards~~ or "competency-based" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.

2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.

3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.

4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with

disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.

5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.

6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee's disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.

7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990
1. Our AMA urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.

2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.

3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.

4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.

5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.

6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee's disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.

7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations.
CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities.
BOT Rep. 19, I-21

Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment H-140.825

The Council believes that a more general formulation that did not delineate specific actors would better emphasize the importance of fairness whenever and by whomever such assessment is sought and would help ensure that guidance remains evergreen. The Council therefore proposes to amend Opinion 9.3.2 by insertion as follows:
E-9.3.2 – Physician Responsibilities to Colleagues with Illness, Disability or Impairment
Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession. While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume

practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.
As individuals, physicians should:
(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.
(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.
Collectively, physicians should nurture a respectful, supportive professional culture by:
(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.
(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.
(h) Eliminating stigma within the profession regarding illness and disability.
(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.
(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to ~~that will~~ ensure patient safety and practice competency. (II)
CEJA Rep. 3, A-22

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and

mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.
CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18; Modified: Res. 322, A-22

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.
Res. 220, I-17

Medical Care of Persons with Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical

education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.
4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often

found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.
CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22

Increase Employment Services Funding for People with Disabilities 90.010MSS
AMA-MSS will ask the AMA to support increased resources for employment services to reduce health disparities for people with disabilities.
MSS Res. 020, A-21

MSS Standard Procedure for Accommodations in USMLE and NBME Exams 295.201MSS
AMA-MSS will ask the AMA to: (1) collaborate with medical licensing organizations to facilitate a timely accommodations application process; and (2) in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities.
MSS Res. 11, I-19

Expanding Support for Medical Students and Physicians with Disabilities 295.241MSS
AMA- MSS will prioritize the input, direction, and partnership of members with personal and lived experience of disability, especially those with intersecting marginalized identities, to ensure those most impacted guide the direction of change.
MSS CDA CME Report A, A-22

Improving Support and Assistance for Medical Students with Disabilities 310.055MSS
AMAMSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM).
MSS Res 33, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 05
(A-23)

Introduced by: Erin Albertini, Julia Meguro, and Sarah Rinehart, University of Miami.

Subject: Inclusive Language for Immigrants in Relevant Past and Future AMA Policies

Sponsored by: Region 2, Region 4, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Undocumented immigrants are foreign-born non-citizens who have either bypassed inspection at a US border or have remained in the country beyond their required departure date according to their visa[1]; and

Whereas, The term “illegal immigrant” implies criminality and is reductive, leading to discrimination, dehumanization, and a negative sentiment surrounding immigration[2-4]; and

Whereas, The term “alien” in reference to immigrants implies othering and carries negative connotations of invaders, contributing to fearful sentiments towards immigrants and invoking prejudice[5]; and

Whereas, Anti-immigration rhetoric and xenophobia leads to poor quality of care, discrimination and othering within the health system, and avoidance of necessary healthcare due to prejudice[6,7]; and

Whereas, Policies endorsing an anti-immigration climate limit the health outcomes and utilization of healthcare systems by undocumented immigrants[8,9]; and

Whereas, As of 2013, the Associated Press Style Book no longer sanctions the term "illegal immigrant," and only sanctions the use of the word "illegal" in reference to an action as opposed to a person[10]; and

Whereas, President Biden ordered immigration agencies to utilize the term "undocumented noncitizen" instead of "illegal alien" in 2021 in an effort to create a more humane Customs and Border Protection force and to emphasize respect for human dignity[4]; and

Whereas, Our AMA has previously promoted the elimination of the term “illegal immigrant” due to its dehumanizing nature and instead supported the use of “undocumented immigrant” as an equity-focused alternative[11]; and

Whereas, Our AMA has paid special attention that proper language is utilized when advocating for and working with populations to prevent harm and discrimination through actions such as publishing the Advancing Health Equity Guide[11,12]; and

Whereas, Our AMA has previously passed resolutions on inclusive language in health care, such as Resolution D-65.990, which stipulates the use of “LGBTQ” in past and future AMA policies in order to promote inclusivity in health care for LGBTQ patients[13]; and

Whereas, Active AMA policies H-130.967, D-160.988, H-290.983, H-160.956, H-255.989, and H-255.985 contain the stigmatizing terms “illegal,” “legal,” and “aliens” in reference to immigrants and non-citizens; therefore be it

RESOLVED, That our AMA will utilize the terms “documented," "undocumented," "immigrant,” and/or “noncitizen” in all future policies and publications when broadly addressing the United States immigrant population; and be it further

RESOLVED, That our AMA will revise all relevant and active policies to utilize the term “documented/undocumented immigrant” in place of the terms "legal/illegal immigrant" where such text appears; and be it further

RESOLVED, That our AMA will revise all relevant and active policies to utilize the term “immigrant/noncitizen” in place of the term "alien" where such text appears.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-65.950 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC's Health Equity Guiding Principles for Inclusive Communication that may be used in AMA policies and position statements.

D-65.990 Utilization of "LGBTQ" in Relevant Past and Future AMA Policies: Our AMA will: (1) utilize the terminology "lesbian, gay, bisexual, transgender, and queer" and the abbreviation "LGBTQ" in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation "LGBTQ" in place of the abbreviations "LGBT" and "GLBT" where such text appears; and (3) revise all relevant and active policies to utilize the terms "lesbian, gay, bisexual, transgender, and queer" to replace "lesbian, gay, bisexual, and transgender" where such text appears.

H-130.967 Action Regarding Illegal Aliens
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available.

D-160.988 Financial Impact of Immigration on American Health System
Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the

financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

H-290.983 Support of Health Care to Legal Immigrants
Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

H-160.956 Federal Funding for Safety Net Care for Undocumented Aliens
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.

H-255.989 A Program for Exchange Visitor Physicians
(1) It is the AMA's policy to separate the issues involved in the support of alien physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their native lands from the issues involving U.S. citizens who are graduates of foreign medical schools and alien physician graduates of foreign medical schools who seek permanent residence in the United States. (2) The AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land.

H-290.983 Support of Health Care to Legal Immigrants
Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 06
(A-23)

Introduced by: Cecily Negri, Southern Illinois University School of Medicine; Sarah Costello, University of Iowa Carver College of Medicine; Yuan Xie, Kansas City University College of Osteopathic Medicine; Jay Devineni, University of Missouri-Columbia School of Medicine; Syeda Akila Ally, University of Illinois College of Medicine; Renato Guerrieri, UTHealth Houston McGovern Medical School; Whitney Stuard, UT Southwestern; Ida Vaziri, UT Health San Antonio; Brooke Taylor, University of South Carolina School of Medicine Greenville; Sara Kazyak, Aila Rahman, Wayne State University School of Medicine; Shreya Mandava, University of Virginia School of Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine

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

Sponsored by: Region 2, Region 3, Region 5, Region 7, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Diversity, Equity, and Inclusion (DEI) programs are formal offices, resources, and structures that promote expansion of community representation at an institution, advocate for equal access to opportunities, and increase overall sense of belonging and respect among individuals;[1−3] and

Whereas, The majority of medical schools host diversity initiatives including, but not limited to, community outreach, pathway programs for underrepresented in medicine (URM) individuals, and free clinics;[4] and

Whereas, Academic medical centers rely on medical students, often historically underrepresented in medicine (URM) individuals, to promote diversity initiatives;[5−6] and

Whereas, “Minority tax” includes the cumulative effects of additional responsibilities placed on minority faculty and trainees to promote DEI initiatives, which can detract from other academic endeavors and emotional well-being and lead to burnout and exits from the DEI space;[7−16] and

Whereas, DEI work at academic medical institutions is hindered by limited financial support, limited dedicated staff, directives skewed toward broad generalities, and under-appreciation and under-compensation of the trainees, community members, and scholars engaged in these missions;[17] and

Whereas, Faculty and staff may be discouraged from participating in DEI initiatives considering only 35.6% of medical schools offer incentives for employees to meet DEI goals and 43.6% have career advancement policies as a reward for DEI work;[18] and

Whereas, Ongoing state and federal actions, such as limiting funding to institutions that support DEI initiatives and opposing affirmative action, threaten to hinder initiatives that promote diversity in the physician workforce;[19–23] and

Whereas, The Supreme Court of the United States (SCOTUS) anticipated ruling on affirmative action cases brought forth my Students for Fair Admissions (SFFA) in 2023 poses a significant threat to the promotion of DEI at higher education institutions;[24] and

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

RESOLVED, That our AMA recognize the negative consequences that Minority Tax has on medical faculty and trainees; and be it further

RESOLVED, That our AMA will collaborate with the AAMC, LCME, and relevant stakeholders to encourage academic institutions to utilize DEI activities and community engagement as criteria for faculty and staff promotion and tenure; and be it further

RESOLVED Our AMA will amend D-295.963 Continued Support for Diversity in Medical Education by addition and deletion as follows:

D-295.963 Continued Support for Diversity in Medical Education
Our AMA will: (1) publicly state and reaffirm its ~~stance on~~ support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; ~~and~~ (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Continued Support for Diversity in Medical Education D-295.963
Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

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

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

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

workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.
Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22

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

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

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

discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 07
(A-23)

Introduced by: Emily Heinrich, Caroline Cassidy, Riley O'Keefe, Toni Tornberg, Central Michigan University College of Medicine

Subject: The Stigma Surrounding "Noncompliant" Language in Patient Charting

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Medication adherence is defined as whether or not a patient follows the provider instructions for any given medication regimen[1,2]; and

Whereas, The term "noncompliance" can be defined as either intentionally or unintentionally opposing the medical plan or advice given by a healthcare provider[3,4]; and

Whereas, The term "nonadherence" is defined as a patient who does not actively take part in the health plan agreed upon with their physician or does not take responsibility for the lack of abidance with a health care regimen[3,4]; and

Whereas, The term "nonadherence" has been used interchangeably with "noncompliance" in both literature and patient charting, even if patients are not intentionally varying from their treatment plan[5,6]; and

Whereas, Medication nonadherence can be observed in upwards of 40-50% of patients diagnosed with a chronic disease, such as hypertension and diabetes, and is not corrected when patients have proper insurance with drug benefits[7,8]; and

Whereas, Medication nonadherence is associated with many negative consequences, including an increased number of avoidable hospital admissions, rising healthcare costs, and less than optimal outcomes[3,8,9]; and

Whereas, Many social determinants of health are correlated with medication adherence, including food security, housing stability, and employment status[10,11]; and

Whereas, Medication compliance issues are multifaceted; there are many reasons that patients struggle to adhere to the prescribed regimen, including drug cost, patient-perceived importance of the medication, poor patient education, medication side effects, and cultural differences between patients and providers [6,7,9,12-15]; and

Whereas, In a study of polypharmacy related to medication nonadherence, 70% of patients cited costs-related barriers to filling their prescriptions[7,16,17]; and

Whereas, Many providers attach the term “noncompliant” to patients of racial minorities, those with non-private insurance, and individuals from low-income zip codes associating those populations with stubborn refusal to follow provider instruction[18-21]; and

Whereas, Labeling patients as “noncompliant” or “nonadherent” can impose bias and judgment from physicians and other healthcare providers that may follow those patients throughout their medical journey[21,22]; and

Whereas, Instead of introducing implicit bias and judgment by labeling patients “noncompliant”, providers can focus on a more personalized form of care that addresses potential barriers to treatment adherence[6]; and

Whereas, If physicians are able to recognize the different factors contributing to noncompliance, they may be able to intervene and prevent adverse events, for example, by improving patient education and coaching, utilizing motivational interviewing techniques, and partaking in shared decision making [2,6,7,15,23,24]; and

Whereas, There are current gaps in clinical methods and studies to address patient adherence and how to eliminate the bias that may be associated with the term, as medical nonadherence is a multidimensional set of decisions made by patients[7]; and

Whereas, Our AMA states that the they will partner with other organizations to advocate for the use of non-stigmatizing language specifically when using ICD-10 codes in patient charts to reduce condemning terminology (AMA policy D-70.942); and

Whereas, A current AMA policy specifies the use of non-stigmatizing language in all materials in regard to addiction and substance abuse terminology, highlighting the importance of non-stigmatizing language, but no such policy exists regarding the use of noncompliance (AMA policy H-95.917); therefore be it

RESOLVED, That the AMA study whether the addition of a qualifying “due to” clause after including the terms “noncompliant” or “nonadherent” in a patient chart is effective in reducing bias and stigmatization of patients; and be it further

RESOLVED, That the AMA encourage the use of “I” statements and motivational interviewing by providers with patients labeled as “noncompliant” or “nonadherent” to identify potential barriers in their access to healthcare.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Person-First Language for Obesity H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

Use of Person-Centered Language H-140.831
Our AMA encourages the use of person-centered language.

Restricting Derogatory and Stigmatizing Language of ICD-10 Codes D-70.942
Our AMA will collaborate with the Centers for Disease Control and Prevention and the National Center for Health Statistics ICD-10 Coordination and Maintenance Committee to advocate for the World Health Organization to adopt destigmatizing terminology in ICD-10 and future ICD codes and to eliminate existing stigmatizing diagnostic synonyms.

Destigmatizing the Language of Addiction H-95.917
Our AMA will use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 08
(A-23)

Introduced by: Hanna Malik and Eli Schantz, Indiana University School of Medicine

Subject: Opposing Pay-to-Stay Incarceration Fees

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, "Pay-to-stay" fees refer to fees charged to incarcerated individuals for their own incarceration, including for room and board[1]; and

Whereas, Forty-nine states have some form of pay-to-stay provision, with incarcerated individuals being charged up to $249 per day by the state of Connecticut; $80 per day in Maine; $80 per day in Kentucky; $66.09 per day at the Corrections Center of Northwest Ohio; and $20 per day in Alabama[2-5]; and

Whereas, The majority of incarcerated individuals are unable to pay these fees, as average wages for incarcerated individuals span from $0.13 to $1.30 per hour, and in the first year after their release, 80% of formerly incarcerated individuals earn less than $15,000, while 49% earn $500 or less,[6-7]; and

Whereas, With a collection rate of only 10 to 15 percent, pay-to-stay fees do not contribute any significant economic benefit to taxpayers, yet become permanent on the credit records of individuals leaving incarceration if not paid within 180 days from release, impacting their ability to find stable employment and housing[5,8,9]; and

Whereas, Pay-to-stay fees keep incarcerated individuals trapped in a cycle of poverty and imprisonment, as debts related to these fees, among other legal-financial obligations, hinder re-entry, contribute to recidivism, cause long-term debt and damaged credit, and lead formerly incarcerated individuals to forgo basic necessities in order to make payments[10-12]; and

Whereas, a first- to second-quartile increase in county-wide incarceration rates corresponds to a 2.5% increase in that county's mortality rate, and a standard-deviation increase in incarceration rates leads to 2.9 excess deaths from communicable diseases and 26 excess deaths from non-communicable diseases per 100,000 county population within one year[13,14]; therefore be it

RESOLVED, That our AMA, in partnership with relevant stakeholders, oppose charging incarcerated individuals for room and board, and support federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Reducing the Burden of Incarceration on Public Health. D-430.992
1. Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable

employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.

2. Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. MSS Res 902, I-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 09
(A-23)

Introduced by: Morgan Hopp, Rowan Lovich, Yezan Hassan, Kari Strauss, Jessica Tseng, Creighton University School of Medicine, Phoenix Arizona;
Priya Desai, Boston University Chobanian and Avedisian School of Medicine

Subject: Treating Traumatic Injury Survivorship as a Chronic Condition

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In 2020 the Centers for Disease Control and Prevention reported that unintentional injury was the fourth leading cause of death in all age groups, and within that group traumatic injury accounts for more than 50% of these accidents[1]; and

Whereas, Long-term health of traumatic injury survivors indicates that three years after injury, patients continue to have limitations in all quality of life domains, including but not limited to mobility, pain, self-care and ability to perform their activities of daily living; and

Whereas, Traumatic injury has increased social burden beyond death with the most significant social burden being poor future quality of life including disability and mental health disorders of traumatic injury survivors[2]; and

Whereas, Patients with severe or life threatening injuries are most likely to become a traumatic injury survivor as case fatality rates are only 5% and 20% respectively[3]; and

Whereas, The current standard of care provided comprehensive care during the inpatient stay including rehabilitative services, screening for mobility limitations and safe transitions[A] but, upon discharge, the outpatient system is fragmented with rehabilitation services lacking the appropriate resources such as discharge planning and appropriate transition to home health agencies to sustain positive long-term health outcomes[1,B] ; and

Whereas, Fragmented care postoperatively is associated with 50% higher odds of mortality[C]; and

Whereas, Avoidable and unnecessary emergency department (ED) visits and admissions occur most often in the 12 months following discharge post injury, for concerns such as infection that could have been addressed in an outpatient setting but usually are not due to the breakdown of care following discharge[3]; and

Whereas, A study with over one hundred traumatic injury patients found that 32% of survivors experience either Post-Traumatic Stress Disorder (PTSD) or depression, with 23% experiencing both[3]; and

Whereas, Untreated PTSD secondary to direct trauma is associated with up to 2.5 higher likelihood to develop cardiovascular disease[D]; and

Whereas, PTSD and depression contribute to poorer outcomes and access to a trauma psychiatrist and behavioral health services should be the standard of care for survivors to attain long term optimal outcomes[3-4]; and

Whereas, Among patients with high-risk of developing PTSD or chronic pain, there is greater engagement in comprehensive multidisciplinary trauma follow-up care[6]; and

Whereas, Integrated care teams, (e.g. behavioral health social worker, psychiatrist, trauma surgeon, and a nurse practitioner) that coordinate care to be delivered in the same day decrease number of follow-up appointments and improve accessibility to treatment for patients who have limited access to transportation[3]; and

Whereas, Multidisciplinary outpatient "trauma quality of life clinics," comprised of a nurse practitioner or surgeon, psychologist, social worker, and physical therapist, reported improvement in no-show rates as compared to the standard care visit with an advanced practitioner or surgeon, with no show rates for the standard of care visits being 40% compared to 22% for trauma quality of life clinics[6]; and

Whereas, Multidisciplinary outpatient trauma clinics also resulted in a decreased instance of injury related ED presentations and hospital readmissions[3]; and

Whereas, Patients undergoing follow-up care at a multidisciplinary "trauma quality of life clinic" completed 23 psychology visits in addition to their appointment with the multidisciplinary team versus one psychology visit at a standard of care follow-up clinic[6]; and

Whereas, Adult trauma patients with low resilience, as defined by a validated Trauma Quality of Life (T-QoL) survey, were more likely to report decreased functional outcomes, chronic pain, and PTSD at six months post-injury which suggests screening for resilience in trauma patients can inform appropriate interventions in long-term follow-up care plans in clinic[7]; and

Whereas, Stakeholder organizations such as The American Trauma Society, Brain Trauma Foundation, The Trauma Survivor Foundation, Pediatric Trauma Society, American Association for the Surgery of Trauma, Orthopedic Trauma Association, American College of Surgeons - Committee on Trauma and American Academy of Orthopedic Surgeons endorse comprehensive continuity of care to improve the long term effects of traumatic injury survivors[8-15]; and

Whereas, AMA policy H-345.984 outlines integration of comprehensive health care including general medical care, mental health care, and substance use disorder into existing training programs' clinical settings; therefore be it

RESOLVED, That our AMA-MSS recognizes (1) the impact of traumatic injury survivorship on our healthcare and social resources; (2) the chronicity of comprehensive rehabilitation following traumatic injury; and be it further

RESOLVED, That our AMA supports efforts to increase access to comprehensive care and improved quality of life strategies and interventions for traumatic injury survivors including, but

not limited to, resilience screenings, multidisciplinary clinics, and appropriate long term care plans.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Good Palliative Care H-70.915
Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.

Quality Management Principles H-450.970
Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive continuously to improve the quality of health care; (2) encourages the ongoing evaluation of continuous quality improvement models; (3) promotes implementation of effective quality improvement models; and (4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management.

Definition of Quality H-450.975
Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree to which care services influence the probability of optimal patient outcomes.

Quality of Care - Essentials and Guidelines for Quality Assessment H-450.995
(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient;

(b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions;
(c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care;
(d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process;
(e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources;
(f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare;
(g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and
(h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed.
(b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable.
(c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible.
(d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment.
(e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach.
(f) Both explicit and implicit criteria are useful in assessing the quality of care.
(g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.
(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.
(i) The quality assessment process itself should be subject to continued evaluation and modification as needed.

Quality Improvement of Health Care Services H-450.971
Our AMA will continue to encourage the development and provision of educational and training opportunities for physicians and others to improve the quality of medical care.

Patient Satisfaction and Quality of Care H-450.982
Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the

measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality.

Guidelines for Quality Assurance H-450.988
The AMA believes that the following guidelines should be utilized in any medical peer review system: (1) The general policies and processes to be utilized in any quality assurance system should be developed and concurred with by the professionals whose performance will be scrutinized, and should be objectively and impartially administered.
(2) Any remedial quality assurance activity related to an individual practitioner should be triggered by concern for that individual's overall practice patterns, rather than by deviation from specified criteria in single cases.
(3) The institution of any remedial activity should be preceded by discussion with the practitioner involved.
(4) Emphasis should be placed on education and modification of unacceptable practice patterns rather than on sanctions.
(5) The quality assurance system should make available the appropriate educational resources needed to effect desired practice modifications.
(6) Feedback mechanisms should be established to monitor and document needed changes in practice patterns.
(7) Restrictions or disciplinary actions should be imposed on those practitioners not responsive to remedial activities, whenever the appropriate professional peers deem such action necessary to protect the public.
(8) The imposition of restrictions or discipline should be timely, consistent with due process.
(9) Quality assurance systems should be structured and operated so as to assure immunity for practitioners conducting or applying such systems who are acting in good faith.
(10) To the degree possible, quality assurance systems should be structured to recognize care of high quality as well as correcting instances of deficient practice.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 10
(A-23)

Introduced by: Leslie Gonzalez, Diana Arredondo, Michaela Stamper; Northeast Ohio Medical University; Phat Chang, The George Washington University

Subject: Addressing Overconsumption of Poor-Nutritional-Quality Foods

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, From 2000 to 2020, the prevalence of obesity has increased from 30.5% to 41.9% and the prevalence of severe diabetes rose from 4.7% to 9.2%[1]; and

Whereas, After routine care visits for adults and children, there were a greater number of office visits in 2019 in the United States (US) that included a diagnosis of essential hypertension than any other diagnosis, followed by visits that included a diagnosis of type 2 diabetes mellitus[2]; and

Whereas, Obesity is the leading risk factor for type II diabetes which affects over 30 million Americans[3]; and

Whereas, Obesity contributes to the development of cardiovascular disease[4-5]; and

Whereas, High daily sodium intake is associated with increased risk of obesity[6-7]; and

Whereas, In a prospective cohort study of 7056 individuals over seven years, simple sugar intake in drinks and fruit juice showed increases in cancer risk ranging from 30% to 51% in multivariable-adjusted models[8]; and

Whereas, Simple added sugars in excess, which are often found in drinks fruit juices, are known to directly cause metabolic derangements, mitochondrial damage, insulin and leptin resistance, and energy deficiencies which promote obesity[9]; and

Whereas, In a study of 21,919 participants over 12 years, there was a 60% higher risk of diabetes in those who ate a diet within the highest quintile of energy density compared to those who a diet within the lowest quintile of energy density[10]; and

Whereas, Obesity increases the risk of cardiovascular disease mortality and all-cause mortality[11]; and

Whereas, Our AMA supports including more explicit, graphic, and effective health warnings for tobacco products indicating the risks of smoking, including disease and death (H-495.989)[12]; and

Whereas, Labeling on cigarettes reduces positive perceptions of smoking and increase contemplation to quit smoking[13]; and

Whereas, Among youth in the US, health risk labeling on e-cigarettes has been shown to decrease intention to use e-cigarettes and increased perceived harm by e-cigarettes[14]; and

Whereas, In the US and other developed nations, obesity now accounts for more deaths than smoking[15-16]; and

Whereas, The Food and Drug Administration (FDA) already requires the disclosure of calories, total fat, saturated fat, trans fat, cholesterol, sodium, total carbohydrates, sugars, fiber, and protein for standard menu items in restaurants and food establishments that are part of a chain with 20 or more locations, with at least the calories displayed on menus and menu boards[17]; and

Whereas, Many other countries, including Canada, Mexico, Chile, Peru, and Uruguay, are implementing policies that include the use of front-of-package (FOP) labels to designate foods that are "high" in calories, sugar, fat, or other micronutrients harmful in excess[18-19]; and

Whereas, After implementation of Chile's Law of Food Labeling and Advertising in 2016, a study of monthly household purchasing activity from January 2015 to December 2017 showed a 23.7% decrease in the purchase of "high-in" beverages by volume, a 27.5% decrease in the calories purchases from "high-in" beverages, and a 7.5% decrease in the calories purchased from all beverages[20]; and

Whereas, A 2019 study of 3584 Canadians aged 13 or older demonstrated that, compared to participants who saw no FOP labels, those who saw labels designating "high in" foods purchased less sugar, saturated fat, and calories in the beverage purchasing tasks and less sodium and calories in the food purchasing tasks[21]; and

Whereas, Our AMA recommends that nutrition information in fast-food and other chain restaurants include calorie, saturated fat, trans fat, and sodium labeling on printed menus and, at a minimum, calories on menu boards (H-150.945)[22]; and

Whereas, Our AMA encourages the FDA to develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value (H-150.974)[23]; and

Whereas, Diets lower in fat and sodium have been found to be effective in the prevention and management of hypertension and thus limiting the scope of policy to added sugars neglects the potential impact of expanded front-of-package warning guidelines[24]; therefore be it

RESOLVED, That our AMA amend policy D-150.974, Support for Nutrition Label Revision and FDA Review of Added Sugars, by addition and deletion to read as follows:

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.

2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA.

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars, sodium, saturated fats, and calories based on the established recommended daily values; and (b) include language in warnings about increased risk for diabetes, cardiovascular disease, and cancer. ~~limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.~~

Fiscal Note: Minimal

Date Received: 04/10/2023

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22. Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-food and Other Chain Restaurants H-150.945. See below.
23. Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974. See below.
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RELEVANT AMA AND AMA-MSS POLICY

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.

2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.

2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.

Accurate Reporting of Fats on Nutritional Labels H-150.939
Our AMA urges the Food and Drug Administration to require the use of more precise processes to measure the fat content in foods, particularly trans fats and saturated fats, and to require that the most accurate fat content information based on these processes be included on food labels.

Increasing Awareness of Nutrition Information and Ingredients Lists H-150.948
Our AMA supports federal legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase

SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students; (5) recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives; (6) supports that any excise taxes are reinvested in community programs promoting health and (7) will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.

Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-food and Other Chain Restaurants H-150.945
Our AMA:
1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;
2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners.

Tobacco Product Labeling H-495.989
Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the

United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

Caffeine Labeling H-150.988
The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label.

Increasing Customer Awareness of Nutritional Information and Ingredients Lists in Restaurants and Schools 150.015MSS
AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu items, available to their customers on request.

Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children 150.041MSS
AMA-MSS will ask the AMA to advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 11
(A-23)

Introduced by: Carson Hartlage, Delia Sosa, Emery Lu, Harsimran Makkad, Arielle Martinez, University of Cincinnati College of Medicine; Hailey Greenstone, Tufts University School of Medicine,; Ishaan Rischie, University of Virginia School of Medicine; Amanda Block, Burnett School of Medicine at Texas Christian University; Nimish Saxena, Boston University Chobanian & Avedisian School of Medicine; Charles Adams, Kansas City University College of Osteopathic Medicine; Alexa Lauinger, Carle Illinois College of Medicine; Darian Thompson, University of California Irvine School of Medicine

Subject: Protecting Access to Gender-Affirming Care

Sponsored by: Region 1, Region 5, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Gender-affirming care is defined by the United States Department of Health and Human Services as a “supportive form of healthcare” consisting of “an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people”[1]; and

Whereas, Gender incongruence is refers to when the gender identity of a person does not align with the gender assigned at birth, and gender dysphoria is a condition in which a person with gender incongruence experiences significant burden associated with DSM classification; people experiencing gender incongruence and/or gender dysphoria may or many not identify as transgender or non-binary[2]; and

Whereas, World Professional Association for Transgender Health (WPATH) establishes standards of care for children and adolescents that allow for puberty suppressing hormones (a fully reversible intervention) at onset of puberty, hormone replacement therapy for adolescents who have begun the physical changes of puberty, and limited gender-affirming surgical treatments in some cases[3]; and

Whereas, The Endocrine Society recommends that gender-affirming hormone therapy, which is partially reversible, be offered to adolescents who continue to demonstrate gender incongruence with pubertal hormone suppression, and who demonstrate the ability to provide informed consent, usually beginning at 16 years old[4]; and

Whereas, The American Academy of Pediatrics (AAP) states that gender-affirming medical care for gender-diverse and transgender adolescents may include puberty blockers during puberty and/or cross-sex hormone therapy from early adolescence onward[5]; and

Whereas, Precocious puberty is a condition in which children experience early onset of sex hormone production and is routinely treated with puberty blockers, one of the medications used for the treatment of gender incongruence and dysphoria in youth, but in this context, the use puberty blockers has not been criminalized and/or restricted[6]; and

Whereas, Data from the AAP showed that 50% of transgender male teens, 30% of transgender female teens, and 42% of nonbinary youth reported attempting suicide in their lifetime[7]; and

Whereas, Studies of transgender and non-binary youth and adults show that those receiving gender-affirming hormone therapy or puberty blockers have decreased anxiety and depression symptoms, reduced suicidality, and increased appearance congruence, positive affect, and life satisfaction [8-11]; and

Whereas, The ACLU is currently tracking several hundred anti-LGBTQ bills in the United States, many of which are targeted towards transgender youth and directly outline, ban, and/or criminalize gender-affirming medical and surgical procedures, name them as child abuse, prohibit physicians from providing said procedures by subjecting them to felony charges and/or other legal repercussions, and/or deny public funding or insurance coverage for their provision[12,13]; and

Whereas, As of April 2023, laws that prohibit or restrict access to gender-affirming care for transgender youth have already passed at the state-level in twelve states, and Florida has banned gender-affirming care for minors via votes of the Florida Board of Medicine and Florida Board of Osteopathic Medicine[12,14,15]; and

Whereas, Some proposed bills extend restrictions on gender-affirming care to include transgender young adults up to 21-26 years old in addition to transgender minors and/or effectively ban gender affirming care for all adults by restricting reimbursement for providers or prohibiting coverage with public funds[16-18]; and

Whereas, The Human Rights Campaign reports that over half of transgender youth, ages 13 to 17, have lost or are at risk of losing access to medically necessary gender-affirming care in their state[19]; and

Whereas, Surveys of transgender and gender-diverse youth and parents of these youth show that debates about the rights of transgender people and proposed legislation restricting access to gender-affirming care have negatively impacted mental health and led to increased discrimination for youth[20,21]; and

Whereas, Several states, including Minnesota, Illinois, New Mexico, Vermont, and New Jersey, have enacted bills or policies that protect physicians and patients providing and receiving gender-affirming care and/or declared themselves as “safe haven” states, and several other states have similar bills being introduced[22,23]; and

Whereas, In 2022, Boston Children’s Hospital and Akron Children’s Hospital received threats of violence due to the fact that these hospitals provide gender-affirming care for youth, and the AMA and AAP spoke out against these instances[24-26]; and

Whereas, Several other medical organizations, including the American Academy of Child and Adolescent Psychiatry, American College of Physicians, American Psychiatric Association, American Psychological Association, Endocrine Society, and Pediatric Endocrine Society, have spoken against these bills restricting gender-affirming care for transgender youth[27-32]; and

Whereas, Over the last few years, the AMA has written several correspondences to state governments and the National Governors Association to oppose legislative efforts to restrict and criminalize gender-affirming care for minors[33-39]; and

Whereas, A pending transmittal from the AMA-MSS states that our AMA-MSS "opposes efforts that would prevent transgender or questioning youth from being prescribed puberty-suppressing medications by physicians" (AMA-MSS Policy 60.034); and

Whereas, The AMA supports "treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process" (AMA Policy H-140.824); and therefore be it

RESOLVED, That our AMA will amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," by addition and deletion as follows; and be it further

> **Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927**
> Our AMA (1) recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria and gender incongruence; ~~and~~ (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care; and (4) supports federal, state, and local policies that protect and increase access to gender-affirming care.

RESOLVED, That our AMA opposes any and all criminal and other legal penalties against parents and guardians who support minors seeking and receiving gender-affirming care, including designation as child abuse and alterations to custody status; and be it further

RESOLVED, That our AMA advocate for protections from violence and criminal or other legal penalties for a) healthcare facilities that provide gender-affirming care; b) physicians and other healthcare providers who provide gender-affirming care; and c) patients seeking and receiving gender-affirming care.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824
Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for

gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

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.

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 one's 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 one's gender identity.

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

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.

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

60.034MSS Opposing Efforts that would Prevent Transgender or Questioning Youth from Being Prescribed Puberty-Suppressing Medications by Physicians
AMA-MSS opposes efforts that would prevent transgender or questioning youth from being prescribed puberty-suppressing medications by physicians. (MSS Res. 73, I-19)

RESOLUTION 061 – INCREASING ACCESS TO GENDER-AFFIRMING PROCEDURES THROUGH EXPANDED TRAINING AND EQUITABLE REIMBURSEMENT
RESOLVED, That our AMA advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education; and be it further
RESOLVED, That our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers.
RESOLVED, the AMA-MSS supports an “informed consent” model for coverage of gender affirming care that does not require evaluation by

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 12
(A-23)

Introduced by: Steven Nadakal, University of Louisville School of Medicine; Danielle Graves, University of Louisville School of Medicine

Subject: Access to Torture Documentation for Asylum Seekers

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The Center for Victims of Torture estimates that 44% of refugees, asylees, and asylum seekers in the United States fled from torture and evidence suggests that torture has long-term consequences for refugee health[1-3]; and

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Whereas, United Nations Office of the High Commission adopted a resolution, the Istanbul Protocol, stating that victims of torture have a right to prompt and effective investigation of their experience and the United States joined this agreement[4]; and

Whereas, Guidelines and recommendations for the evaluation of survivors of torture are outlined and agreed upon by the United Nations and have been expanded upon by forensic pathologists[4,5]; and

Whereas, Objective medical documentation of asylum seekers experiences increased their chances of obtaining asylum in the United States by 39% when compared to the national average between 2008 and 2018[6-8]; and

Whereas, Studies of outcomes for persons who have been deported to their country of origin have found high rates of poverty, estrangement, distress, stigma, and sometimes reimprisonment and remigration[9]; and

Whereas, Survivors of torture have specific health needs especially mental needs compared to the general population and often require long term specialized management for positive outcomes[10-11]; and

Whereas, The United States already offers grants to healthcare systems to support the long-term physical, psychiatric, and sociolegal care of victims of torture, with 36 of these healthcare centers presently using Office of Refugee Resettlement funding across the United States, though funds remain underutilized and asylum-seekers underserved as a result[12]; and

Whereas, Existing AMA policy recognizes the importance of trauma-informed care and the AMA 2020 Comment Letter to the United States Department of Homeland Security stresses AMA's commitment to supporting asylum seekers, asylees, and refugees fleeing the threat of torture[13-16]; therefore be it

RESOLVED, That our AMA work with interested specialty, state, and county medical societies and professional organizations and relevant US departments such as the United States Department of Health and Human Services Office of Refugee Resettlement to ensure that all asylum seekers can access screenings for torture and forensic medical and psychological evaluations free of charge by clinicians with relevant expertise in documenting experiences of torture in ways that identify the best approaches for medical intervention, including helping aid victims maintain legal residency status and avoid re-traumatization.

Fiscal Note: Minimal

Date Received: 04/10/2023

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14. AMA. Human Rights H-65.997. Last Modified 2014.
15. AMA. Adverse Childhood Experiences and Trauma Informed Care H-515.952. Last Modified 2021.
16. AMA. Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women D-345.982. Last Modified 2022.

RELEVANT AMA AND AMA-MSS POLICY

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.

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes **trauma-informed care** as a practice that recognizes the widespread impact of **trauma** on patients, identifies the signs and symptoms of **trauma**, and treats patients by fully integrating knowledge about **trauma** into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based **trauma-informed care** in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other **trauma** at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and **trauma-informed care** approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or **trauma** at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and **trauma-informed care** into undergraduate and graduate medical education curricula.

Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women D-345.982
Our AMA will advocate for: (1) increased research funding to evaluate the validity, efficacy, and implementation challenges of existing mental health screening tools for refugee and migrant populations and, if necessary, create brief, accessible, clinically-validated, culturally-sensitive, and patient centered mental health screening tools for refugee and migrant populations; (2) increased funding for more research on evidence-based mental health services to refugees and migrant populations and the sex and gender factors that could increase the risk for mental disorders in refugee women and girls who experience sexual violence; (3) increased mental health training support and service delivery funding to increase the number of trained mental

health providers to carry out mental health screenings and treatment; (4) and encourage culturally responsive mental health counseling specifically.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 13
(A-23)

Introduced by: Joseph Kessler, Maham Alvi, Josh Harris, Hafsa Hassan, Abigail Miller, Balakrishna Brahmandam, Northeast Ohio Medical University; Rebecca Pontius, Katherine Jensen, University of South Carolina School of Medicine; Jesse Garcia, University of California San Diego

Subject: Wearable Devices to Protect High-Exposure Occupations

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, High-exposure occupations, such as firefighting, are at an increased risk of lung disease and cardiovascular disease mortality;[1-4] and

Whereas, Incidence and hazard ratios for preventable diseases such as noise-induced hearing loss, ischemic heart disease, myocardial infarction, elevated cortisol levels, and chronic obstructive pulmonary disease are higher for high-risk occupations compared to the general population due to increased exposure to trauma, environmental hazards, chemicals, and stress;[5, 6, 41] and

Whereas, Current occupational safety recommendations lack protocols to measure vital signs indicative of acute medical emergencies;[7,8] and

Whereas, Wearable devices can prevent negative health outcomes and reduce the likelihood of accidents in individuals working in high-exposure occupations by providing real-time monitoring and analysis of various biometric and environmental data points;[9-30] and

Whereas, The use of internet of things (IoTs) has been demonstrated to reduce the risk of work-related falls, diseases, and fatalities for first responders, including firefighters;[31-33] and

Whereas, Remote monitoring of vital signs in an unobtrusive form, such as a t-shirt, allows for effective monitoring without interference in responsibilities;[34-39, 41] and

Whereas, Data collection and analysis from wearable devices have the potential to advance the reliability and safety of the user;[16, 40, 42-43] and

Whereas, The National Institute for Occupational Safety and Health (NIOSH) and the National Institute of Biomedical Imaging and Bioengineering (NBIB) can assist in the research and funding process for the creation and distribution of safe and effective wearable devices in high-exposure occupations;[44-45] and

Whereas, The National Institute of Standards and Technology provides guidelines for the implementation of wearable devices;[46]

Whereas, The Health Information Technology for Economic and Clinical Health (HITECH) Act encourages the implementation and meaningful use of health information technology, such as wearable devices;[47-49] and

Whereas, Health information collected from wearable devices may be disclosed in compliance with the Health Insurance Portability and Accountability Act security rule using waivers upon hiring, disclosing data collection for health monitoring while in high-exposure operations;[50, 51] therefore be it

RESOLVED, That our AMA-MSS collaborates with relevant stakeholders, such as NIOSH and NBIB, to advocate for studying the efficacy of implementing physiologic monitoring through IoTs in the form of non-obstructive wearable devices; and be it further

RESOLVED, That our AMA-MSS supports the development of wearable devices to expand capabilities for improving reliability and safety of users in high-exposure occupations.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

8.11 Health Promotion and Preventive Care

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.

(b) Educate patients about relevant modifiable risk factors.

(c) Recommend and encourage patients to have appropriate vaccinations and screenings.

(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.

(e) Collaborate with the patient to develop recommendations that are most likely to be effective.

(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.

(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

(h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.

(j) Advocate for healthier schools, workplaces and communities.

(k) Create or promote healthier work and training environments for physicians.

(l) Advocate for community resources designed to promote health and provide access to preventive services.

(m) Support research to improve the evidence for disease prevention and health promotion.
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. Issued: 2016

1.2.11 Ethically Sound Innovation in Medical Practice
Innovation in medicine can span a wide range of activities. It encompasses not only improving an existing intervention, using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, or interventions they employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

(a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.

(b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.

(c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.

(d) Be sensitive to the cost implications of innovation.

(e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

(f) Base recommendations on patients' medical needs.

(g) Refrain from offering such services until they have acquired appropriate knowledge and skills.

(h) Recognize that in this context informed decision making requires the physician to disclose:

(i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

(ii) why the physician is recommending the innovative modality;

(iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;

(iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;

(v) what conflicts of interest the physician may have with respect to the recommended therapy.

(i) Discontinue any innovative therapies that are not benefiting the patient.

(j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

(k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.

(l) Require that physicians who adopt innovations into their practice have relevant knowledge and skills.

(m) Provide meaningful professional oversight of innovation in patient care.

(n) Encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably.

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. Res. 502, I-21

Policing Reform D-65.987
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide

proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. BOT Rep. 2, I-21

Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research 480.018 MSS
AMA-MSS will ask that our AMA study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (MSS Res 15, I-16) (AMA Res 509, A-17 Existing Policy H-480.943 Reaffirmed in lieu of Res 509) (Reaffirmed: MSS GC Report A, I-21)

Supporting HIPAA Coverage of Patients Mobile Health Data 480.026 MSS
Our AMA-MSS supports HIPAA or HIPAA-like requirements for all mobile health applications and wearable health technology such that data collected by these applications and devices is afforded the same privacy protections as standard medical records. (M

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 14
(A-23)

Introduced by: Margaret DeBell, Jessica M. McAllister, Washington State University Elson S. Floyd College of Medicine; Jared Boyce, University of Wisconsin School of Medicine and Public Health

Subject: Strategies to Mitigate Child Abuse and Neglect

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Child maltreatment is defined by the World Health Organization as the physical, sexual, and/or emotional abuse and neglect of children under the age of 18 years[1]; and

Whereas, One in seven children in the United States experienced abuse or neglect within the last year, the probability of which being five times higher for children in families with low socioeconomic status[2]; and

Whereas, The COVID-19 pandemic exacerbated factors that contribute to child maltreatment including unemployment, financial stress, depression, and difficulties in relationships[3]; and

Whereas, Studies have shown that the COVID-19 pandemic increased adolescent experiences of physical abuse from 5.5% to 11% and emotional abuse from 13.9% to 55%[4]; and

Whereas, The percentage of Emergency Department visits for child abuse and neglect that resulted in hospitalization increased from 2.1% in 2019 to 3.2% in 2020 at the start of the COVID-19 pandemic[5]; and

Whereas, Suggested strategies for pediatricians to help prevent child abuse and neglect include connecting families with community resources such as parenting classes or home visitation programs in addition to offering information about respite care[6]; and

Whereas, Crisis nurseries, also called respite nurseries, provide temporary emergency child care in the setting of immediate crises, most commonly parental stress, job or educational emergency, and medical emergency, and also help mitigate the negative effects of trauma on child development[7,10]; and

Whereas, Children whose families utilized services provided by crisis nurseries were 65% less likely to be placed in foster care, and families who used crisis nursery services in conjunction with foster care services were twice as likely to be reunited with their biological families following foster care placement than families that did not have access to crisis nursery services[8,9]; and

Whereas, Caregivers have reported an average of 2.6 out of 7.0 total points to measure reduction in stress, 6.59 out of 7.0 for reduction in potential for abuse and neglect, and 6.4 out

of 7.0 for level of enhancement of parenting skills after receiving support and services from crisis nurseries[10]; and

Whereas, Over a twelve month period following the implementation of crisis child care services in Iowa, one study showed a statistically significant decrease in the state reported incidence of child maltreatment in counties that offered these services, while counties that did not offer this intervention experienced no decline in maltreatment over the same time period[11]; and

Whereas, Current AMA policy outlines physician awareness, training, and reporting standards surrounding child abuse and neglect, however, no policy exists to address solutions to mitigate child abuse and neglect (H-515.960, D-515.982, H-515.965, H-515.988, H-515.981); therefore be it

RESOLVED, That our AMA promotes implementation of child abuse mitigation strategies; and be it further

RESOLVED, That our AMA encourage further studies into strategies to mitigate child abuse and neglect, including but not limited to crisis nurseries.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Identifying and Reporting Suspected Child Abuse H-515.960
1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians. 2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention. 3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse. 4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse. 5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust. 6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims. 7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers. 8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982
Our AMA will work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected.

Child Protection Legislation H-60.948
The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes.

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 suppor 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.

Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes H-515.988
Our AMA (1) reaffirms existing policy supporting repeal of the religious exemption from state child abuse statutes; (2) recognizes that constitutional barriers may exist with regard to elimination of the religious exemption from state medical practice acts; and (3) encourages state medical associations that are aware of problems with respect to spiritual healing practitioners in their areas to investigate such situations and pursue all solutions, including legislation where appropriate, to address such matters.

Family Violence - Adolescents as Victims and Perpetrators H-515.981
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 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.

Curriculum in Child Abuse and Neglect 295.007MSS
AMA-MSS will ask the AMA to urge all US medical schools to include in their required curriculums both formal lectures and clinical instruction in the subject of child abuse and

neglect. (AMA Sub Res 136, A-85, Adopted [H-515.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-515.994 Rescinded: CSAPH Rep. 1, A-13) (Reaffirmed: MSS Res 13, A-14) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 15
(A-23)

Introduced by: Archita Goyal, Nishanth Ganeshbabu, Hailey Greenstone, Julianna Mastropierro, Nathan Barger, Zahida Sheikh, Benjamin Cole, Jane Branch, Shivangi Patel, Gabi Orbach, Jessica Ding; Tufts University School of Medicine; Phat Chang; The George Washington University; Varnica Bajaj, Boston University School of Medicine; Vedika Karandikar, University of Connecticut School of Medicine

Subject: Opposing Private Equity Acquisitions of Healthcare Practices

Sponsored by: Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Private Equity (PE) funds may be defined as pooled investments used to buy controlling shares of companies or other entities[1]; and

Whereas, PE funds streamline acquired businesses by cutting costs and reducing the involvement of prior physician owners, intending to sell the businesses for a profit in three to seven years, on average[1]; and

Whereas, PE firms seek to reduce health care solely to a means of financial gain by consolidating decision-making power and chasing financial targets rather than delivering high quality health care in an efficient manner[2]; and

Whereas, PE acquisitions lead to overutilization of high margin, low value services and increase pressure to up-code charges[3]; and

Whereas, PE penetration is highest in dermatology, gastroenterology, ophthalmology, obstetrics and gynecology, and orthopedics[4]; and

Whereas, PE acquisitions perpetuate gaps in health equity by accepting fewer Medicaid patients, increasing charges, increasing case mix indices, and more aggressively coding resulting in higher patient risk scores [3,5]; and

Whereas, PE annual deal values in health care have increased from $41.5 billion in 2010 to $119.9 billion in 2019 for a total of $750 billion over the last decade[2]; and

Whereas, PE acquisition of nursing homes led to a loss of 160,000 life-years and a 50% increased probability of patients receiving antipsychotic medications which are associated with greater mortality in the elderly population[6]; and

Whereas, Data from 15,000 unique skilled nursing facilities showed that PE ownership increased short-term mortality of Medicare patients by 10% (nearly 20,150 lives lost over the

twelve-year study period) despite taxpayer spending per patient episode increasing by 11%[7]; and

Whereas, Hospitals acquired by private equity firms have higher charge-to-cost (7.7) ratios compared to non-acquired hospitals (4.8) inducing higher payments from patients and insurers[8]; and

Whereas, PE-acquired practices experienced a mean increase of $71 (20.2%) in charges per claim and an increase of $23 in allowed amount per claim, representing a 11% increase over the baseline[4]; and

Whereas, PE acquisition has become a short-term lifeline for many smaller, financially distressed health care entities, but often leads to rapid withdrawal due to low profit prospects, leading to the entity's bankruptcy[9]; and

Whereas, PE funds are required to exit for the firm to see financial returns, typically resulting in liquidation of their acquired hospitals through dividend recap from existing debt or complete liquidation/bankruptcy thus giving undue burden to hospitals themselves[10]; and

Whereas, Paladin Healthcare, a PE entity, acquired and ultimately shut down Hahnemann University Hospital in Philadelphia, which predominantly served low-income people of color, leaving them without access to care[9]; and

Whereas, two rural Missouri hospitals, Audrain Community Hospital and Callaway Community Hospital, were acquired by private equity firm Nueterra Capital in 2020 and faced staffing shortages, medication shortages, and emergency room closures despite double administration spending and non-salaried employee benefits spending rising 273% before their closure in 2022[11]; and

Whereas, PE acquisitions of physician practices have largely been exempt from review by the U.S. Federal Trade Commission[2]; and

Whereas, PE firms operate in healthcare without any oversight due to the "complex structure" of their funds[2]; and

Whereas, The corporate practice of medicine is broadly defined as non-physician investment in medical practices[1]; and

Whereas, Many state medical practice acts prohibit the "corporate practice of medicine" due to concerns for interference with physician clinical judgment and the differing obligations of corporations to shareholders versus physicians to patients [12], and

Whereas CMS is studying the impacts of PE in health care which will be released in June; and

Whereas our AMA-MSS has no internal policy on PE; and

Whereas, the PE business model is at direct conflict with the core values of health care: serving patients and communities[2]; therefore be it

RESOLVED, That our AMA-MSS recognizes that acquisition of healthcare practices by PE firms often has detrimental consequences for patients and providers; and be it further

RESOLVED, That our AMA-MSS opposes the acquisition of healthcare practices by PE firms due to their detrimental effects on healthcare access, patient outcomes, and increased financial burden on the health care system.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Establishing Ethical Principles for Physicians Involved in PE Owned Practices D-140.951
Our AMA will study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of PE ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of PE ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices.

The Impact of PE on Medical Training H-310.901
Our AMA will:
1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity.
2. Encourage GME training institutions, programs, and relevant stakeholders to:
a. demonstrate transparency on mergers and closures, especially as it relates to PE acquisition of GME programs and institutions, and demonstrate
institutional accountability to their trainees by making this information available to current and prospective trainees;
b. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure;
c. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty;
d. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels;
e. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners.

3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution.
4. Support publicly funded independent research on the impact that PE has on graduate medical education.
5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on PE to heighten awareness among the physician community.
6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training.
Corporate Practice of Medicine H-160.887
Our AMA acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training.

Corporate Investors H-160.891
1.Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
b. Due diligence should be conducted that includes, at minimum, review of the corporate

investor's business model, strategic plan, leadership and governance, and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 16
(A-23)

Introduced by: Cortland Jell, California Health Sciences University; Alec Calac, UCSD-SDSU Joint Doctoral Program in Public Health; Peter Park, Anne Burnett Marion School of Medicine at Texas Christian University

Subject: Support a Surgeon General Warning for Processed Meat

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Colorectal cancer is the fourth most common type of cancer and second leading cause of cancer death in the United States, with an estimated number of 151,030 new cases for 2022[1,2]; and

Whereas, Incidence of early-onset colorectal cancer has increased an average of 1.8% per year in the United States since 2012, with one-third of colorectal cancer patients being under the age of 55[2,3]; and

Whereas, There is little awareness in the general population of the lifestyle factors that can cause colorectal cancer. In a survey of patients who had been diagnosed with colorectal cancer, the average score of knowledge of colorectal cancer risk factors was a 1.5 on a scale of 1 to 6, indicating very little awareness of the risk factors associated with higher rates of colorectal cancer[4,5]; and

Whereas, The World Health Organization (WHO) and The International Agency for Research on Cancer (IARC) classifies processed meat, defined as meat that has been transformed through salting, curing, fermentation, smoking, or other processes to enhance flavor or improve preservation, as carcinogenic to humans (Group 1), based on more than 800 epidemiological studies[9]; and

Whereas, high processed meat intake was positively associated with risk of breast, colorectal, colon, rectal, and lung cancers[10-12]; and

Whereas, one recent study found that just a 25-g/day increment in processed-meat intake (equivalent to about one thin slice of bacon or one slice of ham) was associated with an 19% greater risk of incident colorectal cancer[13], and another found that the chance of CRC increased by 0.2% for each gram of processed meat intake per week[14]; and

Whereas, The American Cancer Society increased its emphasis on the importance of reducing processed meat consumption in 2020 based on evidence of processed meat as a carcinogen in light of meat consumption project to rise in the United States[15,16]; and

Whereas, of the US population aged ≥2 y, 46.8% reported consuming any processed meat, 42.5% reported consuming processed red meat, and 11.3% reported consuming processed poultry[17]; and

Whereas, When people are made aware of the association between processed meat and colorectal cancer, they are more likely to reduce their processed meat consumption[18]; and

Whereas, Graphic warning labels can increase people's intention to reduce their current levels of meat consumption[19]; and

Whereas, Health warning messages were perceived to be significantly more effective ($p<0.001$) than environmental warning messages at reducing readers 'intentions to consume red meat[20]; and

Whereas, Nutrition labels have been shown to influence consumers to change their shopping behaviors towards healthier products[21];

Whereas, Health warnings have been shown to induce behavioral changes in reduction of tobacco, another Group 1 carcinogen[22]; and

Whereas, When asked to select the most discouraging marker word on a warning label, the largest quantity of participants selected "SURGEON GENERAL WARNING"[23]; and

Whereas, AMA policy H-150.922 supports initiatives designed to increase public awareness of the risks of processed meat consumption and reduce processed meat consumption; therefore be it

RESOLVED, That our AMA will support the issuance of a United States Surgeon General warning on processed meat considered to be carcinogenic, detailing the positive correlation between processed meat consumption and the incidence of gastrointestinal cancers, including colorectal cancer.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Reduction in Consumption of Processed Meats H-150.922
Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. Res. 406, A-19

Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA D-425.990 Our AMA will coordinate with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45. MSS Res 819, I-22

Encourage Appropriate Colorectal Cancer Screening D-55.998
Our AMA, in conjunction with interested organizations and societies, will support 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. MSS Res 510, A-03

Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases H-330.877
1. Our AMA supports requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.
2. Our AMA will continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements. Res. 123, A-17

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.
TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United

States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun. CCB/CLRPD Rep. 3, A-14 Appended: Res. 403, A-14 Appended: Res. 404, A-19 Appended: Res. 905, I-19

Tobacco Prevention and Youth H-490.914

Our AMA:

(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 child care 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;
(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;
(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;
(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
(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). CSA Rep. 3, A-04 Modified: Res. 402, A-13

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 17
(A-23)

Introduced by: Spencer Asay, University of Chicago Pritzker School of Medicine; Kayla Tran, Rosalind Franklin University Chicago Medical School; Rajadhar Reddy, Baylor College of Medicine; Manasvi Khullar, Caitlin Hall, Touro University California; Frankie Granata, Loyola University Chicago Stritch School of Medicine; John Preston Wilson, LSUHS School of Medicine

Subject: Strengthening the Supplemental Nutrition Assistance Program

Sponsored by: Region 2, Region 3, Region 4, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Temporary alterations made to the Supplemental Nutrition Assistance Program (SNAP), including emergency benefit allotments and expanded eligibility for students of higher education, have been crucial to mitigating food insecurity over the course of the COVID-19 pandemic[1–4]; and

Whereas, All pandemic-era alterations to SNAP will expire with the termination of the COVID-19 Public Health Emergency Declaration [expected 11 May 2023], likely resulting in widespread loss of or reduction in SNAP benefit allotments in the face of persistent inflationary pressures[5–7]; and

Whereas, The US Farm Bill, the legislative package through which SNAP is authorized, is set to be reauthorized leading up to its expiration on 30 September 2023, representing a timely juncture in which to substantially improve SNAP and associated nutrition programs pursuant to existing AMA policy[8,9]; and

Whereas, SNAP benefits allotments, which averaged $230 per household per month in the pre-pandemic period of 2020, have historically been insufficient for beneficiaries, with the most recent data indicating that the average SNAP household exhausts more than three-quarters of its benefit allotment by mid-month[10–13]; and

Whereas, In 2021 the USDA reevaluated and updated the SNAP benefit formula for the first time in 15 years to more accurately reflect the cost of a healthy diet, resulting in a 21% increase in average benefit allotments per beneficiary[14,15]; and

Whereas, The 21% average increase in SNAP benefits resulting from the revised benefit formula is estimated to have kept nearly 2.3 million people out of poverty and reduced child poverty by 8.6% in the fourth quarter of 2021[3]; and

Whereas, Despite continued food price inflation, lawmakers have signaled intentions to curtail overall SNAP funding as part of the 2023 US Farm Bill reauthorization, including by means of reversing the aforesaid benefit formula recalculation that resulted in crucial permanent allotment increases[16–18]; and

Whereas, Rates of food insecurity are estimated to be up to 38 percentage points higher among students of higher education compared to the general population; however in 2018, 57% of low-income students potentially eligible for SNAP did not participate in the program[19–21]; and

Whereas, One study found that only 19% of students eligible for SNAP actually utilized its benefits and cited numerous barriers to student SNAP participation, including lack of awareness or misinformation regarding the program, difficulty completing the program application, and assumed ineligibility[20]; and

Whereas, Nutrition assistance programs in the territories of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands are funded by capped annual block grants rather than SNAP[22]; and

Whereas, Despite said US territories experiencing rates of food insecurity at least 20 percentage points higher than the mainland US, the current block grant funding structure permits comparatively less overall nutrition assistance funding and limited flexibility to meet increased need in times of crisis[23–25]; and

Whereas, Documented adult immigrants are subject to a five-year SNAP eligibility waiting period, contributing to limited access to nutrition assistance among this population and a 24% lower SNAP participation rate among households with members of mixed eligibility status compared to fully eligible households with all-US-born members[26–28]; and

Whereas, SNAP benefit allotments are adjusted based on the number of eligible household members, equating to reduced per-capita benefit allotments for families with members having mixed immigration and eligibility statuses[27,28]; and

Whereas, Items eligible for purchase using SNAP benefits do not include hot foods or prepared meals ready for immediate consumption, limiting food options available to beneficiaries and disproportionately impacting those with larger family sizes and those receiving disability benefits[11,29,30]; and

Whereas, The COVID-19 crisis accelerated the implementation of innovative solutions to address the paucity of food options available to low-income or rural communities, such as grocery delivery via online retailers, weekly produce delivery via subscription services, and direct farm-to-consumer produce delivery through Community Supported Agriculture (CSA)[31–33]; and

Whereas, Community Supported Agriculture is an alternative structure of farming that allows consumers to purchase a weekly delivery or membership to the food produced in a season by a local farm by paying a deposit fee at the beginning of the season[34]; and

Whereas, Surveys have documented increased consumption of fruits and vegetables and positive health outcomes among CSA participants[34–36]; and

Whereas, CSA and other produce delivery options are often inaccessible to SNAP recipients due to CSA being billed as a one time payment weeks in advance of produce delivery and the fact that CSA membership/delivery/deposit fees are not covered by SNAP benefits[37]; and

Whereas, The Online Purchasing Pilot allows for SNAP payments to be used for online orders from major retailers, expanding food access to up to 86% of SNAP recipients in certain states, but not for many smaller online retailers offering similar services[38–42]; and

Whereas, Many states operate SNAP Incentive Programs that match SNAP recipients' benefit payments at farmer's markets (or other farm direct outlets, such as CSA) dollar-for-dollar, doubling the purchasing power of program participants[43]; and

Whereas, Studies have shown that increased purchasing power among SNAP beneficiaries at farmer's markets or other farm direct outlets is associated with 26% higher fruit and vegetable consumption and increased benefit spending on fruits and vegetables relative to other food items[44,45]; and

Whereas, Current AMA policy H-150.925 supports efforts to implement innovative food delivery models, but contains no specific language pertaining to subscription-based programs like CSA; therefore be it,

RESOLVED, That our AMA oppose efforts to curtail Supplemental Nutrition Assistance Program benefit allotments and overall program funding; and be it further

RESOLVED, That our AMA support efforts to expand Supplemental Nutrition Assistance Program eligibility and outreach among students of higher education; and be it further

RESOLVED, That our AMA support measures to expand the Supplemental Nutrition Assistance Program to US territories that presently receive nutrition assistance funding via a capped block grant structure; and be it further

RESOLVED, That our AMA support the elimination of the current five-year Supplemental Nutrition Assistance Program eligibility waiting period for all otherwise qualified documented immigrants; and be it further

RESOLVED, That our AMA support measures to classify hot and prepared foods as items eligible for purchase using Supplemental Nutrition Assistance Program benefits; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to advocate for increased funding for nutrition assistance programs, including but not limited to SNAP or SNAP incentive programs, in an effort to increase the individual purchasing power of recipients; and be it further

RESOLVED, That our AMA amend policy H-150.925 by addition to read the following;

> **Food Environments and Challenges Accessing Healthy Food H-150.925**
> Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery, food subscription services, community supported agriculture, and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.

RESOLVED, That our AMA-MSS append this resolution to Pending Transmittal 192, "SNAP Expansion for DACA Recipients," which is set for transmission to the Annual 2023 Meeting of the House of Delegates.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation, A-12; Reaffirmation, A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation, A-14; Reaffirmation, I-14; Reaffirmation, A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable

food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.
Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22

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

Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies H-440.809
Our AMA will oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies.
Res. 216, A-21

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.
Res. 254, A-18

Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs D-440.919
Our AMA: (1) supports reduction and elimination of work requirements applied to the used as eligibility criteria in public assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF); (2) supports states' ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program; and (3) will work with state medical societies to encourage states to establish express lane eligibility (ELE) programs that use eligibility data from the maximum number of Express Lane Agencies (ELAs) feasible, which include SNAP, TANF, and other programs as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children's Health Insurance Program (CHIP).
Res. 215, A-21

Food Stamp Incentive Program D-150.983
Our AMA supports legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables.
Res. 405, A-07

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 18
(A-23)

Introduced by: Kayla Tran, Kate Fahey, Christian Arcelona, Naosuke Yamaguchi, Manasvi Paudel, Jacob Wolf, Harsh Patel, Nandita Gupta, Zohaib Satti, George Peek, Brandon Sedaghat, Aubrey Hong Rosalind Franklin University Chicago Medical School; Alexandra Yorks, Wayne State University

Subject: Advocacy for Secondary Victims of Family Violence

Sponsored by: Region 5, Region 6, Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The term, intimate partner violence, refers to any physical or sexual violence, stalking, or psychological aggression by a current or former dating partner or spouse[1]; and

Whereas, The term domestic violence refers to partner violence but the term can also encompass child or elder abuse, or abuse by any member of a household[2]; and

Whereas, Domestic violence affects approximately ten million people per year and an estimated 45 million children will be exposed to violence during childhood with 90% being direct eye witnesses to the abuse[3]; and

Whereas, Secondary victims are commonly defined as people in the presence of or perceiving domestic violence who can see or hear the act in question[4]; and

Whereas, Secondary victims are typically children, with one in fifteen children being secondary victims of intimate partner violence each year and ninety percent of these cases being eyewitnesses, totaling up to ten million estimated secondary victims per year[5,6]; and

Whereas, Current federally qualifying domestic violence misdemeanors are defined as a crime committed by an intimate partner, parent or guardian of the victim that required the use or attempted use of physical force or the threatened use of a deadly weapon but does not extend to secondary victims[7]; and

Whereas, Individual states each have their own definition of what qualifies as domestic, intimate partner and family violence as well as their own definitions of victims with some states having more narrow definitions than others[8]; and

Whereas, The legal definition of secondary victims varies by state with 10 states and Puerto Rico, applying this definition only to a child who is related to or is a member of the household of the victim or perpetrator of the violence[4]; and

Whereas, Indiana law states that witness criteria only applies to the non-custodial child of a noncustodial parent[4]; and

Whereas, It is estimated that thirty to sixty percent of child secondary victims eventually become primary victims from the initial domestic abuse perpetrator[6]; and

Whereas, Current AMA policy advocates for children who experience trauma under H-515.952 but only for biologically related children and not any other witnesses of domestic violence regardless of relationship; and

Whereas, Secondary victims who witness domestic violence can suffer severe emotional and developmental difficulties that are similar to those of children who are direct victims of abuse as well as greater susceptibility to depression, substance abuse, tobacco use, unintended pregnancies, and are three times as likely to commit crimes and engage in violent behavior than their peers[4,9]; and

Whereas, Secondary victims are at greater risk than their peers of developing an array of age-dependent clinical disorders such as allergies, asthma, gastrointestinal problems, bed-wetting, nightmares, and headaches[10]; and

Whereas, Health insurance companies are prohibited from denying coverage to victims of domestic violence as a preexisting condition[11]; and

Whereas, Victims of domestic violence qualify for a Special Enrollment Period because domestic violence is considered a qualifying life event, although these extensions do not specifically apply to witnesses of domestic violence[12]; and

Whereas, Domestic and family violence is specifically prevalent in low income populations where victims have lower rates of health insurance coverage than non-victims[13]; and

Whereas, For many survivors and witnesses of domestic and sexual violence, access to health care is a vital part of healing and self-determination[12]; and

Whereas, Physicians witness domestic violence across a multitude of specialities including but not limited to emergency medicine, pediatrics, and family medicine as estimated prevalence of domestic violence among female patients is as high as 54%[14]; and

Whereas, Recognizing domestic violence in suspected victims requires physicians to be educated on the psychological, legal, and ethical signs of domestic violence beyond physical illness and injury[15]; and

Whereas, Throughout undergraduate medical education, medical students need to be prepared to fulfill their role as mandated reporters and recognize domestic violence and potential secondary victims[15]; and

Whereas, Current AMA policy H-185.976 opposes the denial of insurance coverage to victims of domestic violence but does not extend to secondary victims of domestic and family violence who may experience similar negative health outcomes as victims; therefore be it

RESOLVED, That our AMA support for the expansion of current family and domestic violence laws to include protections for secondary victims; and be it further

RESOLVED, That our AMA amend H-185.976 by addition to read as follows:

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to all primary and secondary victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence; and be it further

RESOLVED, That our AMA amend H-515.965 by addition to read as follows:

Family and Intimate Partner Violence H-515.965
(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, secondary victims of trauma, and elder abuse ~~and~~. Furthermore, these curricula should provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors and secondary victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests; and be it further

RESOLVED, That our AMA amend H-295.912 by addition to read as follows:

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient and any secondary victims.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS 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 opposes 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.

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 19
(A-23)

Introduced by: Onajia Stubblefield, Caitlin Reichard, Jahnavi Sunkara, University of Louisville School of Medicine

Subject: Support for Diversity and Development of Formal Clinical Criteria for Hair Curl Pattern

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Current literature indicates that many physicians exhibit cultural incompetence in interactions with patients with textured or tightly coiled hair and their hair care routines[1,2]; and

Whereas, Only 3% of dermatologists are Black even though the Black population represents about 13% of Americans[3,4]; and

Whereas, Some physicians may lack a proper understanding of the daily care practices or best treatment for tightly coiled hair (e.g. 3c, 4a, 4b, 4c), which negatively impacts dermatological care of conditions like alopecia for minority groups[1]; and

Whereas, Current dermatology education lacks an objective classification for curl pattern, commonly used on hair products[5]; and

Whereas, Individuals select hair products such as hair relaxers and anti-frizz products based on culturally determined hair classifications, and such hair products have health implications due to exposure to endocrine-disrupting chemicals and carcinogens[6,7]; and

Whereas, Alopecia occurs in both men and women across all racial and ethnic populations, but the etiology varies considerably by group[8]; and

Whereas, In Black women, many forms of alopecia are associated with cultural hair-care practices that alter hair curl pattern (e.g., traction alopecia and central centrifugal cicatricial alopecia)[8]; and

Whereas, Hair care plays familial and social roles in the relationships and identity of individuals with tightly coiled hair[2,9]; and

Whereas, Culturally incompetent physicians can mistake patient non-compliance with the patient participating in deeply held, cultural practices, which undermines the patient-physician relationship and creates barriers in achieving a mutual course of treatment[2]; and

Whereas, AMA policy H-295.853 encourages comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources; however, hair, a key component of dermatological care, is not mentioned; and

Whereas, AMA policy H-295.897 allows for the training and education of medical students, trainees, and physicians in culturally competent care through various methods, including standardized patients, intergroup dialogue, surveys, and dissemination of existing resources, this does not necessarily include the conception of formal clinical criteria concerning hair, in order to best assist this education and training; therefore be it

RESOLVED, That our AMA support hair diversity as a relevant factor in providing culturally competent dermatological care and education; and be it further

RESOLVED, That our AMA support relevant medical societies' efforts to develop formal clinical criteria in identifying hair types to improve medical education and patient care.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Representation of Dermatological Pathologies in Varying Skin Tones H-295.853
Our AMA encourages comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources for medical students, physicians, non-physician healthcare providers and patients.
Res. 505, I-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19 Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22

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 identify, 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.
AMA Principles of Medical Ethics: I,IV,VII,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic

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

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of

cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.
CME Rep. 5, A-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-11 Appended: Res. 304, I-16 Modified: CME Rep. 01, A-17 Appended: Res. 320, A-17 Reaffirmed: CMS Rep. 02, I-17 Appended: Res. 315, A-18 Modified: Res. 322, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 20
(A-23)

Introduced by: Sarah Costello, University of Iowa Carver College of Medicine; Elizabeth Suschana, Krishna Channa, University of Connecticut School of Medicine; Revati Gummaluri, Rowan University School of Osteopathic Medicine; Anjlee Panjwani, SUNY Upstate Medical University; Sophia Vrba, University of Wisconsin Madison; Jooeun Jeong, McGovern Medical School at UTHealth Houston; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine

Subject: Approaches to Reduce Interventions in Childbirth

Sponsored by: Region 2

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Childbirth is one of the most challenging psychological events in a mother's life, as 10–34% of all childbearing women are faced with traumatic birth experience[1]; and

Whereas, An individual's experiences during the vulnerable period of pregnancy, childbirth, and postpartum have the potential to affect their confidence and self-esteem, shape their view of birth and use of maternity care in the future, or impart lasting psychological damage[2]; and

Whereas, A negative experience in childbirth is associated with post-traumatic stress disorder (PTSD), disruption to interpersonal relationships, dysfunctional maternal-infant bonding, reduction in rates of exclusive breastfeeding, inappropriate utilization of maternal and newborn care services, fear of childbirth and increased desire for an elective cesarean section in future pregnancies[1,3,4]; and

Whereas, Spontaneous vaginal delivery at term is the optimal outcome for the majority of birthing people and newborns[5-7]; and

Whereas, Many healthy pregnant people undergo routine obstetric practices that are of limited or uncertain benefit for low-risk individuals in spontaneous labor and may interfere with the physiological process of childbirth[8]; and

Whereas, Results from the *Listening to Mothers III* survey indicate that individuals in the United States routinely experience interventions that are not medically necessary including induction, augmentation and episiotomy and mothers had negative views on intervention in the birth process with almost six in ten respondents strongly agreed (34%) or agreed (25%) with the statement, "Giving birth is a process that should not be interfered with unless medically necessary,"[5]; and

Whereas, Indiscriminate use of medical interventions such as routine amniotomy, continuous electronic fetal monitoring (EFM), restricted movement during labor, restriction of nutrients/fluids and intravenous fluids can negatively affect an individual's childbirth experience, potentially leading to impaired confidence and self-esteem and low maternal satisfaction[9]; and

Whereas, Routine interventions in the first phase of normally progressing labor such as routine amniotomy, continuous electronic fetal monitoring (EFM), and oxytocin induction increase adverse outcomes such as increased neonatal ICU stay, increased need for interventions in the second phase of labor, and increased cesarean deliveries[10]; and

Whereas, Admission in the latent phase of labor is common and has been shown to increase intrapartum interventions, increase the probability of a cesarean section, and increase complications including neonatal resuscitation, admission to special care nursery, and longer hospital stay compared to admission during the active phase of labor[11]; and

Whereas, Patient-centered intrapartum care with minimal medical intervention has been identified as an effective strategy to create a positive birth experience[1]; and

Whereas, Intermittent auscultation is a simple technique to listen to fetal heart tones for short periods of time during labor and its use alone has been found to result in superior maternal and neonatal outcomes and reduction in cesarean deliveries, compared to newer techniques such as routinely used cardiotocography[12]; and

Whereas, Intermittent auscultation and non-pharmacological labor pain control, such as continuous one-to-one emotional support during labor from a doula or chosen friend or family member, have the potential to substantially reduce cesarean deliveries[13,14]; and

Whereas, Continuous one-to-one emotional support during labor has been correlated with increased spontaneous vaginal birth, shorter duration of labor, and decreased instrumental vaginal birth, use of any analgesia, use of regional analgesia, low five-minute Apgar score and negative feelings about childbirth experiences without evidence of harms[13]; and

Whereas, While all pain relief methods in childbirth facilitate perception of control, pharmacological methods reduce labor pain but have negative side effects and nonpharmacological methods may not reduce pain but help individuals cope with the pain of labor and facilitate bonding with professionals and birth supporters, highlighting the need to provide and promote as many approaches as possible[15]; and

Whereas, Walking and upright positions in the first stage of labor reduces the duration of labor, the risk of cesarean birth and the need for epidural, without negative effects on outcomes for mothers and babies[16,17]; and

Whereas, In a study showing validation of the CAVE-st questionnaire, a tool used to assess health science students' attitudes of factors affecting birth experiences, results showed that avoiding unnecessary medical intervention during childbirth is a goal of perinatal education programs for health professional students[18,19]; and

Whereas, In studies comparing midwifery-models of care, an approach that promotes low-intervention, physiological birth in low-risk pregnancies, compared to Obstetrician-provided or family-medicine provided care, mothers were less likely to experience interventions such as amniotomy, episiotomy and instrumental vaginal birth (forceps/vacuum), with improved or similar maternal and neonatal outcomes and high maternal satisfaction[20]; and

Whereas, In 2018, The National Partnership for Women & Families released *The Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*, recommending interprofessional education (IPE) for maternity care professionals and limiting use of consequential interventions in lower-risk women[21]; and

Whereas, Family Medicine and Obstetrics and Gynecology residency programs are increasingly employing an interdisciplinary approach to facilitate exposure to low-intervention, physiological childbirth for medical trainees by including midwifery involvement in graduate medical education[22,23]; and

Whereas, Sharing patient care and lacking knowledge of interprofessional roles of midwifery staff is identified as a challenge in undergraduate medical training, and IPE in medical education can include simulation based education and collaboration with midwifery students in team-based learning[24]; and

Whereas, The World Health Organization (WHO) recommends against routine amniotomy and recommends the use of intermittent auscultation, one-to-one support, freedom of movement, options for non pharmacological pain management, and delayed admission during latent labor for all healthy pregnancies in order to promote a positive childbirth experience[8]; and

Whereas, American College of Obstetrics and Gynecology (ACOG) recommends against routine use of continuous EFM, routine amniotomy, and routine continuous infusion of intravenous fluids for spontaneous labor at term with a fetus in vertex presentation[25]; and

Whereas, ACOG recommends that labor management be individualized (depending on maternal and fetal condition and risks) to help birthing people meet their labor and birth goals including techniques such as intermittent auscultation, nonpharmacologic pain relief, continuous support, and delayed admission in the latent phase of labor[25]; and

Whereas, American Academy of Family Physicians (AAFP) recommends low-interventional approaches such as continuous support during labor and delivery and delayed admission until active phase of labor for group B streptococcus (GBS) negative patients to support improved

birth outcomes and recommends against continuous EFM and routine amniotomy to reduce negative birth outcomes[6]; and

Whereas, Our AMA policies H-185.917 and D-420.993 encourage the development of strategies to prevent disease conditions that contribute to poor obstetric outcomes and promote access to risk-appropriate care, however these policies do not address patient-centered approaches to limit unnecessary medical interventions for the intrapartum management of low-risk women in spontaneous labor; and

Whereas, Our AMA policy D-295.934 encourages interprofessional education among health care professions students, however this policy does not recognize the importance of interprofessional approaches to expose medical trainees to low-intervention childbirth; therefore be it

RESOLVED, That our AMA amend policy H-185.917, "Reducing Inequities and Improving Access to Insurance for Maternal Health Care," by addition as follows:

Reducing Inequities and Improving Access to Insurance for Maternal Health Care, H-185.917

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best

practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care, including low-intervention, patient-centered approaches for the intrapartum management of low-risk women in spontaneous labor; and be it further

RESOLVED, That our AMA supports interprofessional approaches to expose medical trainees to low-intervention childbirth.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Disparities in Maternal Mortality D-420.993
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
1. Our AMA recognizes that interprofessional education and partnerships are a priority of the American medical education system.
2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
5. Our AMA supports the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.
6. Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

Obstetrical Delivery in the Home or Outpatient Facility H-420.998
Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.

Pain Management Following Cesarean Birth D-420.990

Our AMA:

(1) supports a stepwise, multi-modal approach to analgesia management (which may include nonpharmacologic and pharmacologic therapies including opioids) using a shared decision-making approach to minimize pain and improve function after cesarean birth with the goal of transitioning to other methods of pain control for long term;
(2) will work with hospitals and relevant stakeholders to support the adoption of enhanced recovery after surgery protocol for cesarean section to optimize recovery and improve function while decreasing use of opioid medications for pain; and
(3) supports counseling of women who are prescribed opioid analgesics following cesarean birth about the risk of central nervous system depression in the woman and the breastfed infant.
(Res. 514, A-19)

High Rates of Cesarean Deliveries 420.006MSS
AMA-MSS will ask the AMA to (1) support the American Congress of Obstetricians and Gynecologists' opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and (2) encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use. (MSS Res 10, I-13) (AMA Res 706, A-14 Not Adopted)
(Amended and Reaffirmed: MSS GC Rep A, I-19)

Increasing Support for Doula Services to Reduce Maternal Mortality 420.019MSS
AMA- MSS supports Medicaid coverage for doula services. (MSS Res. 011, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 21
(A-23)

Introduced by: Kiersten Walsworth, Adam Chaban, Jovan Jande, Aila Rahman, Maria Tjilos, Shruthi Ilango, Wayne State University School of Medicine; Carson Hartlage, University of Cincinnati College of Medicine; Krista Chen, Johns Hopkins University School of Medicine; Brooke Taylor, University of South Carolina School of Medicine Greenville; Julia Versel, Loyola University Chicago Stritch School of Medicine

Subject: Inclusion of Harm Reduction Curricula in Undergraduate Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Harm Reduction has been defined as "…policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" and encompasses a variety of health and social services and practices, including but not limited to: overdose prevention and reversal, needle and syringe programs, opioid agonist therapy (e.g. methadone and buprenorphine), supervised consumption sites, drug checking, and providing information about safer drug use[1]; and

Whereas, Drug overdoses remain one of the leading causes of injury-related death in the United States and have demonstrated an upward trending incidence since the 2010s, with over 106,000 persons dying from drug-related overdoses in 2021[2-3]; and

Whereas, Harm Reduction practices have been shown to decrease mortality rates associated with drug overdose, as evidenced by the 1,258 overdose reversals that were performed by naloxone that had been distributed to community members by the Harm Reduction Institute (HRI) in Orange County, CA, within 1.5 years of the program opening[4]; and

Whereas, Harm Reduction practices are believed to decrease the transmission and overall prevalence of infections such as HIV and Hepatitis C by preventing shared use of injection equipment, with one study indicating a 62% decline in this activity amongst its participants who had Hepatitis C[5]; and

Whereas, Patients who are experiencing substance misuse display increased utilization of the healthcare system and accumulate an average of $1,000 more in services compared to non-drug users, however, Harm Reduction has been shown to decrease the financial and physical burden on healthcare systems by preventing the need for hospitalization secondary to overdose and other substance related issues[6-9]; and

Whereas, A portion of healthcare providers may be unaware about what Harm Reduction is, how it can help patients, and how it can be integrated into clinical settings, with one study indicating merely 15.6% of providers feeling confident in their ability to refer patients to needle exchange/syringe access programs, despite 84.6% believing it is their responsibility as a physician to perform that task[10-13]; and

Whereas, Healthcare provider stigma towards individuals with substance use disorder can lead to discriminatory clinical care, with one study indicating that primary care physicians with high levels of stigma were 34% less likely to prescribe opioid use disorder (OUD) medications to eligible patients and other studies associating stigma with the misattribution of physical illness symptoms to substance misuse symptoms leading to poorer patient outcomes[12,14-17]; and

Whereas, Harm Reduction training effectively decreases both healthcare provider and medical student stigma towards individuals with substance use disorder[18-19]; and

Whereas, The inclusion of Harm Reduction education within medical student education has been demonstrated to increase both student knowledge about Harm Reduction, and student preparedness to engage with Harm Reduction techniques and resources when consulting future patients by up to 51%[11,20-23]; and

Whereas, Medical students that participated in a Drexel University naloxone training program report an average 84% increase in confidence that they would be able to effectively handle an overdose situation involving another person[24]; and

Whereas, It is inferred that information and attitudes acquired during UME will be carried into the role of graduate medical student and thereafter, physician, thereby demonstrating the importance of including Harm Reduction philosophy and techniques in UME to ensure that the future of healthcare is one that values and prioritizes the inclusion of Harm Reduction in patient care; and

Whereas, Our AMA recognizes the importance of healthcare workers who are educated in Harm Reduction practices and encourages the inclusion of Harm Reduction curriculum through Continuing Medical Education credits related to topics such as opioid agonist therapy[25]; and

Whereas, According to D-95.987, H-95.932, and H-95.954, our AMA recognizes the value of Harm Reduction practices for the improvement of patient outcomes; and

Whereas, According to D-95.987, our AMA supports the education of healthcare providers in Harm Reduction methods, however D-95.987 does not expand this support to include medical students, does not address the role of UME in accomplishing this goal, and does not provide an actionable plan for accomplishing this goal; and

Whereas, According to H-95.932, our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively, however H-95.932 does not provide guidance for the implementation of such training, including but not limited to training within UME; and

Whereas, According to D-295.327, our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their

standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum, however D-295.327 only broadly mentions public health and does not identify harm reduction as a pertinent component of a comprehensive public health curricula; and

Whereas, There is precedent for our AMA supporting the inclusion of definitive and precise topics within UME which are exemplified by resolutions such as H-295.890, H-295.897, as well as other resolutions related to medical education; and

Whereas, There is no currently existing AMA policy specifically addressing Harm Reduction curricula in medical education in order to prepare future physicians to engage with patients experiencing substance misuse; therefore be it

RESOLVED, That our AMA promote the inclusion of Harm Reduction education within current UME curricula as a key component to developing a physician workforce that are confident in their ability to work with patients experiencing substance misuse in a humane and compassionate manner; and be it further

RESOLVED, That our AMA will work with relevant stakeholders to encourage medical schools to incorporate Harm Reduction education as part of their current UME curricula, acknowledging that appropriate knowledge, skills, and attitudes regarding substance use disorders can improve patient outcomes and reduce public health burden; and be it further

RESOLVED, That our AMA encourages the development of a curriculum inventory and database in Harm Reduction practices and philosophy for use by medical schools in UME; and be it further

RESOLVED, That our AMA supports the development of national standards for Harm Reduction training in the UME curricula; and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows:

Prevention of Drug-Related Overdose, D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers<u>, undergraduate medical students,</u> and people who use drugs about the use of naloxone and other Harm Reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address Harm Reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for Harm Reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for Harm Reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

Fiscal Note: Minimal

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RELEVANT AMA AND AMA-MSS POLICY

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for

the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other Harm Reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address Harm Reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for Harm Reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for Harm Reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of Harm Reduction.

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 22
(A-23)

Introduced by: Ashwin Varma, Long School of Medicine

Subject: Supporting Efforts to Strengthen Competition in U.S. Healthcare Provider Markets

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In the United States, healthcare services are primarily provided via markets in which private provider organizations provide care to individuals who primarily finance healthcare via commercial employer-sponsored insurance[1]; and

Whereas, Markets depend on robust competition to encourage low prices, high quality, and innovation[2]; and

Whereas, There has been a tremendous amount of horizontal consolidation (defined as a reduction in the number of competitors who sell similar services) in U.S. healthcare markets in the last 20 years; for example, the American Hospital Association documents 1,577 hospital mergers from 1998 to 2017[3-8]; and

Whereas, As a result of the wave of horizontal consolidation, most U.S. hospital and physician specialist markets are considered 'highly concentrated' by the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division, indicating that there are too few competitors to maintain healthy competition[3-8]; and

Whereas, Empirical evidence consistently demonstrates that horizontal consolidation in healthcare markets results in patient harm through significant price increases, with the magnitudes of such price increases ranging from 20-65%[9-17]; and

Whereas, The evidence base surrounding the effect of horizontal healthcare on mergers on price is robust and consistent; studies arrive at consistent conclusions despite using different datasets, separate evaluation methods (including retrospective analysis of consummate mergers), multiple timeframes, and despite originating from separate research groups (both academic and governmental)[9-17]; and

Whereas, While direct effects of price increases resulting from horizontal consolidation are borne by insurers, patients ultimately bear the burden of increased healthcare prices through out-of-pocket payments for insured patients, direct exposure to prices for uninsured patients, and/or indirectly through premium increases and/or wage decreases[18-19]; and

Whereas, In addition to raising prices charged to insurers, consolidation in healthcare markets is also causally tied to lower scores on relevant healthcare quality metrics, including increased mortality for surgical procedures[20-25]; and

Whereas, Evidence suggests that mergers in healthcare markets tend to lead to lower wages paid to physicians because physicians have industry-specific skills which are not easily portable to out-of-industry occupations[26] ; and

Whereas, Vertical consolidation (in which a health system purchases smaller physician practices) has also become increasingly common in the U.S. healthcare system; evidence demonstrates the share of hospital-owned physician practices in the US more than doubled over the past twenty years and that 40-50% of all physicians are currently employed by large health systems[3,7, 27] ; and

Whereas, As with horizontal consolidation, evidence suggests that vertical consolidation results in acquired practices changing their referral patterns to favor the acquiring hospital, which may be a form of 'anticompetitive steering' that tends to reduce patient choice sets and insulates acquiring firms from competition for referred services, resulting in higher inpatient and outpatient prices[28-33]; and

Whereas, Dominant health systems (those with a significant share of their local market) have engaged in a number of business practices which have raised concern for their effects on competition, specifically the use of 'anti-steering' clauses which prevent insurers from incentivizing patients to choose unaffiliated providers and anti-transparency or 'gag' clauses, which prevent insurers from revealing prices and quality scores to patients[34-36] ; and

Whereas, Anti-steering and gag clauses were the subject of two recent antitrust cases, the case brought by the DOJ against Carolinas Health System and the case brought by the California Attorney General's against Sutter Health System, the former of which resulted in a settlement barring the health system from future use of restrictive steering clauses[34-36] ; and

Whereas, One key reason for the inability of existing merger enforcement to prevent harmful healthcare consolidation is the lack of competition policy funding relative to a surge in merger activity; while healthcare merger activity rose 50% from 2010-2020, the FTC & DOJ budgets declined over the same period and the per-case resource intensity of antitrust litigation increased[,37-40]; and

Whereas, The inability of competition policy agencies to prevent vertical consolidation is primarily due to flaws in the current merger reporting system in which most vertical mergers in healthcare markets are not required to be reported to the FTC & DOJ because they fall beneath the $50 million (as adjusted) threshold for mandatory merger reporting (despite accounting for $30-40 billion in total value)[37-40]; and

Whereas, The FTC is currently unable to enforce the antitrust laws against not-for-profit entities, which account for over 45% of all U.S. hospitals, significantly impeding the ability of competition policy authorities to prevent harmful consolidation[37-40]; and

Whereas, Despite the preponderance of evidence that healthcare consolidation (both vertical and horizontal) and anticompetitive conduct has resulted in adverse healthcare market performance, the FTC and DOJ have been hesitant to bring enforcement actions to court due to

difficulties faced in winning cases, including a string of losses in the early 2000s and recent cases in which they have only prevailed after resource-intensive appeal[37-41]; and

Whereas, The difficulty faced by competition authorities in court primarily stem from the extremely high evidentiary burdens faced by the FTC in winning cases; specifically, under current standards, the FTC and DOJ must show that a merger will lead to "likely harm to competition", which raises the resource intensity of litigation and makes judges more hesitant to block mergers[37-41]; and

Whereas, Although the FTC has the power to retrospectively challenge mergers and has done so in the past, the FTC prefers to challenge mergers prior to completion and the majority of merger challenges in the healthcare industry have been made prior to merger completion[37-40]; and

Whereas, Due to the failure of adequate enforcement of antitrust laws in the past two decades and the resultant high concentration of a majority of U.S. healthcare markets, restoring effective competition will likely require retroactive challenge of a significant number of prior mergers[3, 37-40]; therefore be it

RESOLVED, That our AMA oppose not-for-profit firm immunity from Federal Trade Commission competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals; and be it further

RESOLVED, That our AMA advocate to adequately resource competition policy authorities such as the Federal Trade Commission and Department of Justice Antitrust Division to perform oversight of healthcare markets; and be it further

RESOLVED, That our AMA support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny; and be it further

RESOLVED, That our AMA support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, which may include but not be limited to a) Simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) Encouraging the FTC to leverage its authority under Section 7 of the Clayton Act to increase the frequency of retroactive challenges to healthcare mergers.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Health System Consolidation D-215.984
Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit

of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting.

Hospital Consolidation H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Health Care Entity Consolidation D-383.980

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 23
(A-23)

Introduced by: Jovan Jande, Maria Tjilos, Zarin Kothari, Aila Rahman, Alexandra Yorks, Wayne State University School of Medicine; Charlene Norgan Radler, Texas Christian University School of Medicine; Varna Kodoth, Loyola University Chicago Stritch School of Medicine

Subject: Advocating for Collaboration with Private Insurers to Provide Coverage of Clinically Validated Self-Measured Blood Monitoring (SMBP) Devices and Develop Physician Compensation Models for SMBP Related Care

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Self-measured blood pressure (SMBP) monitoring is defined by the American Medical Association (AMA) and American Heart Association (AHA) as the measurement of BP by an individual outside of the office at home[1]; and

Whereas, In 2019, the AHA published guidelines in support of remote blood pressure monitoring provides as an opportunity for healthcare providers to follow-up with patients facing chronic, life-threatening cardiovascular diseases (CVD) and reducing the burden of CVD in the long term; and

Whereas, The Global Burden of Disease Study 2019 identified high systolic blood pressure was a leading global risk factor for attributable deaths and the leading risk factor for persons aged 50-74 years and 75 years and older, accounting for 10.8 million of all deaths in 2019[2]; and

Whereas, According to the CDC, nearly half of US adults, approximately 116 million individuals, have hypertension, defined as a systolic BP greater than 130mmHg and diastolic BP greater than 80mmHg, or are currently taking medication for the treatment of hypertension[3]; and

Whereas, The number of individuals in the US with uncontrolled hypertension has increased by 3.4% from 2009 to 2020, from 48.2% to 52.8%[4]; and

Whereas, The surgeon general's Call to Action recognizes hypertension as a national crisis and strongly recommends the widespread implementation of SMBP to achieve high levels of hypertension control across US communities and reduce the negative health consequences associated with hypertension[5]; and

Whereas, Research shows that SMBP monitoring has significant potential to improve the diagnosis and management of blood pressure disorders such as hypertension[1]; and
Whereas, This improved management of hypertension is due to the advantages of home blood pressure monitoring which include: the monitoring of longitudinal daily readings, the

neutralization of white-coat syndrome, detecting masked hypertension and unexpected variability in BP, and monitoring if treatments have been consistently successful[6]; and

Whereas, SMBP, when combined with co-interventions that include medication titration, patient education and lifestyle counseling, results in a clinically significant reduction in blood pressure (BP)[7,8]; and

Whereas, Adherence to recommended hypertension therapy requires health behavior change, and SMBP has been indicated in international guidelines and scientific statements for empowering patients in BP management[9,1]; and

Whereas, SMBP has been argued to be more suitable for routine clinical practice given the greater availability of higher levels of acceptability and tolerance in patients, as compared to Ambulatory Blood Pressure Monitoring, for example[10]; and

Whereas, Studies have shown that there are potential improvements in health equity as a result of SMBP, as it has been demonstrated what SMBP used with remote monitoring reduced BP in minority, low-income and rural populations with hypertension[11]; and

Whereas, Medicare currently does not cover the cost of an at home blood pressure monitor unless a beneficiary is undergoing kidney dialysis[12]; and

Whereas, Clinically validated home blood pressure cuffs - according to the American Medical Association's established criteria - can cost anywhere from $30 to $300[13]; and

Whereas, Medicare only reimburses physicians one time for SMBP patient education at a rate of $11.19, and monthly for SMBP data review related to clinical decision making at a rate of $15.16[14]; and

Whereas, There is general lack of coverage for home blood pressure monitors for hypertension diagnosis and management amongst the top 20 private insurers by covered lives[15]; and

Whereas, Adoption of SMBP on a national level has been projected to prevent nearly 16.5 million false positive hypertension diagnosis, saving insurers an average of $254 per members, by reducing medical management of hypertension when not needed, thereby reducing the risk of adverse effects and costs associated with prolonged medication use[16]; and

Whereas, While there are challenges associated with SMBP, such as psychological distress of patients associated with continuous reminders of their condition and difficulty operating the devices, patient education by the physician and regular check-ins can mitigate these issues - both of which can be increased with proper reimbursement[17]; and

Whereas, According to D-480.991 and past policy statements put out with the American Heart Association, our AMA supports working with the Centers for Medicare and Medicaid Services to cover the cost of devices, but has not yet clarified the same support to advocate for private insurer coverage of devices and adequate physician compensation models; and

Whereas, According to H-185.951 and H-330.885, our AMA has specifically recognized the importance of advocating for insurer coverage of other clinically validated and useful devices for patient self-monitoring; and

Whereas, Without proper insurer coverage of clinically validated SMBP monitoring devices and sufficient reimbursement for physician tasks associated with SMBP, there remains great challenges with adoption; therefore be it,

RESOLVED, That our AMA collaborates with private insurers to increase coverage of clinically validated self-measured blood pressure monitoring (SMBP) devices for patients with diagnosed hypertension in an effort to improve the management of hypertension; and be it further,

RESOLVED, That our AMA collaborates with private insurers to develop comprehensive insurer compensation models for physicians who spend time educating patients, and managing patient hypertension with self-measured blood pressure monitoring (SMBP) devices.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Access to Medical Care D-480.991
Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.

Pharmacist in Hypertension Screening H-425.998
(1) Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel, for pharmacists and other non-physicians in order to assure adequate personnel for hypertension screening programs.
(2) The medical profession should participate in the development of programs which assure an adequate system for monitoring blood pressure measurement and referring patients when indicated to physicians.
(3) Community programs should be established to educate the public on the importance of participation in screening programs and adherence to subsequently prescribed courses of therapy, with periodic blood pressure measurement and evaluation of the effectiveness of the therapeutic regimen by licensed physicians.
(4) The particular program to be implemented in any community should receive the full support of the medical profession and be built upon the existing community facilities and health personnel resources, taking into consideration applicable state legal restriction or requirements.

Non-Physician Measurement of Body Functions H-35.990
In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to their personal physician.

Genomics in Hypertension: Risk Prediction and Treatment H-460.901
Our AMA encourages continued research on the genetic control of blood pressure, including in pediatric populations, and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension, and supports the view that hypertension clinical trial designs should attempt to reduce phenotypic heterogeneity in order to improve the quality and interpretation of results.

Improvement in US Airlines Aircraft Emergency Kits H-45.981
1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will: (a) support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit; (b) encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits; and (c) encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

Medical Evaluations of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.
Home Anticoagulation Monitoring H-185.951
1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anticoagulation for all medically appropriate conditions.
2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.

3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.

Coverage of Continuous Glucose Monitoring Devices H-330.885
Our AMA supports efforts to achieve coverage of continuous and flash glucose monitoring devices for patients when it is evidence-based and determined appropriate by physicians.

Medicare/Medicaid Coverage of Multi-Use Technology Platforms H-480.948
AMA policy is that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.

Co-Pay Accumulators D-110.986
Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

Home Health Care H-210.994
Our AMA (1) reaffirms its support of home health care as an alternative to hospital, nursing home, or institutional care;
(2) encourages physicians to take a more active role in the provision of home health care;
(3) supports modifications in Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries;
(4) supports improving patient accessibility to home health services by seeking modifications in the Medicare regulations to provide coverage for the care of homebound patients by qualified individuals working under the supervision of the patient's attending physician; and
(5) supports continued monitoring of the adequacy of the home health care system to meet the accessibility needs of homebound patients.

Medical Evaluations of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6)

Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 24
(A-23)

Introduced by: Evelien van Gelderen, Vidya Babu, Serin Baek, Krista Chen, Francesca Giorgianni, Valeria Hernandez-Munoz, Setu Mehta, Alvina Pan, Johns Hopkins School of Medicine

Subject: Supporting Academic Medical-Legal Partnerships to Address Social Determinants of Health

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Social determinants of health (SDOH) can impact as much as 50 percent of variation in health outcomes,[1] and Medical-Legal Partnerships (MLP) are a way to directly address social determinants of health that have a civil law remedy;[2] and

Whereas, Incarceration,[3] substandard housing,[4] gaps in insurance coverage,[5] and food insecurity[6] have been identified as social determinants of health that can be addressed as civil legal needs; and

Whereas, MLPs integrate legal experts into the healthcare team to address patients' unmet legal needs;[7] and

Whereas, Surveys such as the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences created by the National Association of Community Health Centers, the Social Needs Screening Toolkit created by Health Leads, and a ten-question screening tool created by the Centers for Medicare and Medicaid serve as effective screening tools to identify patients with relevant SDOH needs, such as legal needs, in healthcare settings;[2] and

Whereas, MLP lawyers often specialize in addressing social determinants, leading to improved access to retroactive benefits, debt relief, avoidance of utility shutoffs, reduced patient stress, and decreased readmission rates, inpatient stays, and emergency department visits;[8] and

Whereas, the Liaison Committee for Medical Education emphasizes the importance of health disparities and includes competencies in health inequities and ways to address health disparities in its accreditation standards for medical education (M.D.) programs;[9] and

Whereas, Academic Medical-Legal Partnerships (A-MLPs), such as the Health Justice Alliance at Georgetown University, are specifically designed to involve students, facilitate students' skill-building through interprofessional collaboration and reflection on professional identity and advocacy, and teach students about the importance of civil legal needs as social determinants of health;[7] and

Whereas, A 2020 study found that an advocacy training program through the Health Justice Alliance A-MLP improved medical students' knowledge and skills in advocacy and strengthened their professional identities as future advocates;[10] and

Whereas, A 2017 study found that implementing an A-MLP program at Morehouse School of Medicine to educate medical students on medical-legal practices increased student confidence to screen for SDOH issues and ability to refer patients to reliable legal resources;[11] and

Whereas, a 2022 study found that MLP implementation in Florida is impeded by a prevalent lack of knowledge and training among healthcare providers regarding the identification of health-harming legal needs and how to use patient legal advocacy to resolve these needs;[12] and

Whereas, in 2019 only 26 percent of medical schools (out of 148 eligible U.S.-based medical education institutions) were found to be involved in an MLP or A-MLP;[13] and

Whereas, there is no current AMA policy that exists specifically to support the establishment of Academic Medical-Legal partnerships to address social determinants of health and further medical students' education on the role of A-MLPs in patient care; therefore be it

RESOLVED, That our AMA will inform physicians and medical students of the impact of unmet legal needs on the health of patients, particularly with respect to social determinants of health; and be it further

RESOLVED, That our AMA will support the education of medical students and physicians about the value of Medical-Legal Partnerships in addressing patients' unmet legal needs, and ways to screen for these needs; and be it further

RESOLVED, That our AMA will support further research into how to improve Academic Medical-Legal Partnerships' impact on addressing social determinants of health; and be it further

RESOLVED, That our AMA will support the establishment and expansion of Academic Medical-Legal Partnerships and greater incorporation of civil legal needs as Social Determinants of Health into medical school curricula, similar to the Health Justice Alliance at Georgetown University.[7]

Fiscal Note: Minimal

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RELEVANT AMA AND AMA-MSS POLICY

Support for the Establishment of Medical-Legal Partnerships 440.093MSS
1. Our AMA-MSS supports the expansion and development of medical-legal partnerships to better address social determinants of health.

Statement on Interprofessional Relations for Physicians and Attorneys H-265.997
The AMA supports the following statement of interprofessional relations for physicians and attorneys, developed, jointly by the AMA and the American Bar Association. Its purpose is to promote the public welfare, improve the practical working relationships of the two professions, and facilitate the administration of justice.
(1) Medical Reports: Physicians, upon proper authorization, should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony. The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.
(2) Conferences: It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary. Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully disclose and discuss the medical information involved in the controversy.
(3) Subpoena for Medical Witness: Because of conditions in a particular case or jurisdiction or because of the necessity for protecting himself or his client, the attorney is sometimes required

to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

(4) Arrangements for Court Appearances: While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone after the trial has commenced of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.

(5) Physician Called as Witness: The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury. It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence, and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

(6) Fees for Services of Physician Relative to Litigation: The physician is entitled to reasonable compensation for time spent in conferences, preparation of medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions.

(7) Payment of Medical Fees: The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 25
(A-23)

Introduced by: Janki Naidugari, Danielle Graves, University of Louisville School of Medicine

Subject: Access to Restoration of Rights for People with Disabilities

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, 1.3 million American adults with disabilities are estimated to be under active conservatorships wherein a court appointed adult assumes guardianship of the person with a disability;[1] and

Whereas, Under guardianship a person with a disability may lose control of all finances and the right to vote and, where there is not a power of attorney, may also lose the right to make their own medical decisions;[2] and

Whereas, The most recent government reports on guardianship abuse revealed that, despite inadequate oversight from courts, hundreds of allegations of neglect and physical and financial abuse were reported between 1990 and 2010;[3] and

Whereas, The AMA Code of Ethics 2.1.2 supports ethical and shared decision making with patients who lack capacity and AMA Opinion 11.1.1 reiterates this commitment to ethical and informed decision especially for the most vulnerable patients and populations;[4,5] and

Whereas, Restoration of Rights is the process of removing a conservatorship or reinstating some personal control over assets and decision making in an effort to restore equality of opportunity, full participation, independent living, and economic self-sufficiency for persons with disabilities[6], and

Whereas, Though every state has a process for the Restoration of Rights for persons with disabilities, this process is considered underutilized by Florida and North Carolina studies analyzing the use of the Restoration of Rights process; their data suggested that persons under guardianship were not aware of their right to restoration and that this was the primary barrier to access,[7] and

Whereas, Additional barriers identified for persons with disabilities seeking Restoration of Rights included poor access to courts and access to counsel due to the fact that they do not have personal control of their assets;[1] and

Whereas, Where studied, Restoration of Rights petitions were usually submitted by the person under guardianship and were uncontested in the court, suggesting that access and awareness is the primary hurdle;[1] and

Whereas, 20 states have introduced laws allowing for informal petitions for Restoration of Rights and Utah, Texas, Michigan and Minnesota have bills of rights for persons under guardianship informing them of the option of restoration with the most recent of these bills being passed last year;[7,8] and

Whereas, Chairman Bill Casey of the Senate Special Committee on Aging submitted a bill entitled the Guardianship Bill of Rights Act and commenced hearings on the bill in March of 2023 along with releasing a statement calling for the advancement of a national Guardianship Bill of Rights, lending credence to the timeliness of this amendment;[8] therefore be it

RESOLVED, That our AMA amend MSS Transmittal 233 by addition to read as follows:

> RESOLVED, That our AMA support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse; and be it further
>
> RESOLVED, That our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life; and be it further
>
> RESOLVED, That our AMA support notification of conservatees of their option to pursue Restoration of Rights and allow for informal requests for restoration to increase access to these options.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics 2.1.2
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;
(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 26
(A-23)

Introduced by: Kennedi Fitts, Nadieh Rahbari; University of Louisville School of Medicine

Subject: Promoting the Implementation of Environmental Justice within Medical Curriculum

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A recent PNAS study reported that “white people are exposed to 17% less pollution than they consume, while Black and Latinx people are exposed to over 50% more pollution than they consume”[1]; and

Whereas, The above statistic serves as a concrete example of environmental injustice; and

Whereas, Given the disproportionate distribution of ambient environmental factors and their potential effect on the health of individuals of marginalized populations, one can expect only increasing demand for information, services, and treatments from medical professionals going forward”[2;] and

Whereas, A Georgia pediatric study concluded that 53.3% reported patients seriously affected by environmental exposures with just 20% having received training in environmental health[3]; and

Whereas, A survey in Texas reported 86% of family physicians had no environmental health training and almost 92% wanted to learn more about environmental health hazards[3]; and

Whereas, Evidenced by the above statistics, it is likely that physicians are equally if not more, unequipped to address environmental injustice with patients, just as they were regarding environmental health; and

Whereas, To provide a most informed response, physicians need to be clinically competent in environmental justice to adequately treat and advise patients on their rightful involvement in environmental laws; and

Whereas, AMA policy H-295.874 called for a resolution that “supports clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health”; and

Whereas, The implementation of social determinants of health training does not adequately address environmental justice, but instead, focuses on environmental health; and

Whereas, Environmental Health is defined as a branch of public health that focuses on the interconnectedness of people and their environments which advocates for safer communities and healthier environments[4]; and

Whereas, "Environmental Justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation and enforcement of environmental laws, regulations and policies"[5]; therefore be it

RESOLVED, That our American Medical Association strongly encourage the implementation of environmental justice into medical curriculum, during both preclinical and clinical training.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Kennedi: Research into the Environmental Contributors to Disease D-135.997

1. 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.

Climate Change Education Across the Medical Education Continuum H-135.919

1. Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human **health**, and counsel patients on how to protect themselves from the **health** risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and **health** for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Green Initiatives and the Health Care Community H-135.939

1. Our AMA supports: (1) responsible waste management and clean energy production policies that minimize **health** risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and **health** care entities.

Stewardship of the Environment H-135.973

1. 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.

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

1. Our AMA: (1) Supports efforts designed to integrate training in **social determinants of health**, cultural competence, and meeting the needs **of** underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge **of social determinants of health**. (3) Supports medical schools in their efforts to evaluate the effectiveness **of** their **social determinants of health** and cultural competence teaching **of** medical students, for example by the AMA serving as a convener **of** a consortium **of** interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration **of social determinants of health** and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration **of social determinants of health** and cultural competence training in graduate and continuing medical education and publicizing successful models.

Relevant AMA-MSS Policy:

135.021MSS: Environmental Contributors to Disease and Advocating for Environmental Justice

AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows: Research into the Environmental Contributors to Disease and Advocating for Environmental Justice Our AMA will (1) advocate for the 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 and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

440.112MSS: Longitudinal Capacity Building to Address Climate Action and Justice

AMA-MSS will ask the AMA to: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for prompt passage of legislation and policies that limit global warming to no

more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon AMA-MSS Digest of Policy Actions/ 234 neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the House of Delegates.

295.181MSS: Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum

AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations.

MSS Pending Transmittal 73

Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 27
(A-23)

Introduced by: Jonathan Dao, Abram Qiu, John Hoverson, James Garcia, Sidharth Nayak, Montgomery Smith, Shriya Veluri, Leslie Omeire, Long School of Medicine

Subject: Mitigating Drunk Driving Injuries and Fatalities Through Alternative Transportation Programs

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Previous AMA policy, H-30.936, that supports education, legislative solutions, such as a BAC limit of 0.04, and ignition interlocks[1]; and,

Whereas, Education, especially from parents, has measurable effects on decreasing drinking and driving and riding with a drinking driver[2]; and,

Whereas, Implementing decreased blood alcohol concentration (BAC) limits in Utah from 0.08% to 0.05% was associated with an 18% reduction in the motor vehicle crash death rate per mile driven in the first year after it went into effect[3]; and,

Whereas, Implementing alcohol ignition interlocks are associated with 26% fewer impaired drivers involved in fatal crashes, and studies across multiple states have shown a decrease in recidivism rates, including individuals that used interlocks and no longer required them[4, 5]; and

Whereas, Despite previous efforts, driving under the influence continues to be a problem that affects thousands of people each year causing 30% of traffic related fatalities with 11,654 in 2020, which was a 14.3% increase from 2019, 10% of traffic related non-fatal injuries, and 20% of motor vehicle costs ($68.9 billion in 2019)[6-8]; and

Whereas, 50% of impaired drivers state that the place of last drink was a bar or restaurant[9]; and

Whereas, Alternative transportation refers to modes of transportation other than driving one's own vehicle, such as public transportation, ridesharing services, biking, and walking, that are affordable, convenient, accessible, and safe[10]; and

Whereas, The accessibility of public transportation has been shown to significantly reduce the likelihood of patrons intending to drive under the influence of alcohol after visiting bars and restaurants[11-12]; and

Whereas, The expansion of night-buses in Israel, which were intended to serve populations on outings, led to a 37% reduction in total weekend night accidents among 15-29 year olds that suggests a reduction in impaired driving associated with such outings[13]; and

Whereas, Increased access to ridesharing apps, such as Uber, in Portland, Oregon was associated with an absolute reduction of 3.1 alcohol-involved crashes per week[14]; and

Whereas, Increased access to Uber in Houston, Texas was associated with a yearly significant downward trend of impaired driving convictions, and a significant decrease in number of impaired driving convictions on weekends[15]; and

Whereas, Increased access to Uber in Houston, Texas was associated with significant reductions in motor vehicle collision in patients younger than 30 years old, but no significant reduction in older patients, which connects to significantly lower usage in that population[15]; and

Whereas, Access to Uber in California from 2009-2013 has a significant effect on the number of fatalities, but had no significant effect when surge pricing was likely in effect, which demonstrates that price is a barrier to reducing impaired drivers[16]; and

Whereas, In 2018, only about a third of U.S. adults, and only 19% of rural participants have ever used a ride-hailing service, where individuals earning an annual income over $75,000 are twice as likely to use ride-sharing apps than those earning less than $30,000 (53% vs. 24%)[17]; and

Whereas, Rural communities experience disproportionate alcohol and non-alcohol related motor vehicle fatalities due to various factors, including a lack of alternative transportation[18]; and

Whereas, A rural safe ride program, Safe Cab program, in Isanti County, Minnesota demonstrated a 67.6 percent decrease in DUI arrests and a 83% reduction in DUIs from bars that endorse Safe Cab from 2006 to 2014[19]; and

Whereas, In 2015, alcohol related crashes cost Wisconsin over $400 million dollars with 5,174 alcohol related crashes getting an estimated cost per individual alcohol related crash in Wisconsin as $77309.63, and in 2020-21, the Safe Ride program in Wisconsin provided 42,347 free rides home from bars for $355,479 generated from bar fees and DWI fines, which means preventing as little as 5 crashes would save Wisconsin money[20-23]; and

Whereas, Our AMA has supported public transportation in other contexts, such as pollution[24-25] or preventative healthcare[26], but has not supported alternative transportation models, such as ridesharing apps or safe ride programs, that could contribute to the prevention of impaired driving; therefore be it

RESOLVED, That our AMA amend Policy H-30.936 “Prevention of Impaired Driving” by addition to read as follows; and be it further

Prevention of Impaired Driving, H-30.936
Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all

drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; ~~and~~ (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities; and (6) encourages government officials to establish, expand, and continue maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation to provide alternative transportation options for intoxicated drivers.

RESOLVED, That our AMA supports efforts towards increasing social acceptance, public awareness, accessibility, and safety of alternative transportation programs.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

Preventing Death and Disability Due to Particulate Matter Produced by Automobiles H-135.915
Our AMA will: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) support individual states' legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards.

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates

intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Prevention of Impaired Driving H-30.936

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the

driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 28
(A-23)

Introduced by: Maria Tjilos, Kiersten Walsworth, Kaitlin Verkuilen, Mura Abdul-Nabi; Wayne State University School of Medicine

Subject: The Use of Language Interpreters in Medical and Clinical Research

Sponsored by: Region 2, Region 4, Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Individuals who have limited English proficiency (LEP) are defined as those, "...who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English…"[1]; and

Whereas, The role of language interpreters in the healthcare system is to improve communication between patients with LEP and their providers[2]; and

Whereas, Nearly 9% of the United States population, or 25 million citizens, are considered individuals with LEP, a majority of which identify as Latino or Asian[3–5]; and

Whereas, Language barriers cause and perpetuate health inequities within traditionally marginalized communities such as inequities in insurance status, continuity of care, access to healthcare, and chronic disease outcomes, among others[6–12]; and

Whereas, Language concordance and/or use of a certified language interpreter increases patient satisfaction, patient outcomes, and quality of healthcare in patients with LEP[12–18]; and

Whereas, Title VI of the Civil Rights Act mandates certified language interpreter services be provided to patients with LEP when receiving care[19]; and

Whereas, There also exists a lack of representation of individuals from traditionally marginalized racial and ethnic communities in medical and clinical research studies, further exacerbating health inequities due to limited generalizability[20,21]; and

Whereas, Individuals with LEP show low participation in medical and clinical research[22–27]; and

Whereas, Low participation in research from individuals with LEP occurs in part due to the increasing number of studies which excludes research participants who are unable to read, speak, and/or understand English[23,28]; and

Whereas, Nearly 20% of all trials listed on Clinicaltrials.gov between Jan 2019 - Dec 2020 listed English proficiency as a requirement to participate[24]; and

Whereas, Individuals with LEP may not participate in research studies due to medical mistrust, strict eligibility criteria, language differences between patient and research staff, and lack of knowledge regarding the goals and processes of research[25,29,30]; and

Whereas, The lack of translated informed consent forms, increased time needed to consent patients with LEP, and ambiguous guidance from the federal government and related agencies contribute to challenges with recruiting and retaining research participants with LEP[25,26]; and

Whereas, Informed consent is the process in which the research team informs a research participant about the research activities, risks, and benefits in a way which facilitates informed decision making in the participant[31]; and

Whereas, Informed consent should be delivered in the language most easily understood by a participant to facilitate true understanding of research activities in concordance with health beliefs, attitudes, and practices communicated by one's preferred language[32,33]; and

Whereas, Inclusion of language interpreters who understand the research process and the nuances of a particular language facilitates ethical participation of individuals with LEP through accurate portrayal of research expectations without oversimplifying, modifying, or omitting essential information[8,34]; and

Whereas, One study described challenges related to translating informed consent materials such as translation of tone and formality, unintentional errors of omission, and the introduction of complicated research language, among others[35]; and

Whereas, While there is little research investigating the financial cost of using language interpreters in research, it is implicated as a barrier to consenting individuals with LEP in research studies[36,37]; and

Whereas, However, one study found that while use of non-certified language interpreters in the informed consent process was initially less costly, the inaccurate translation incurred further costs downstream that ultimately made the cost of certified language interpreters comparable[38]; and

Whereas, The cost of language interpreters in healthcare is variable, estimates indicate that an in-person language interpretation can cost anywhere between $45-150 per hour or an extra $300 per patient[39,40]; and

Whereas, While federal guidelines outline requirements to provide language assistance to those who require it in healthcare programs and activities (such as research), there has been little success to translate these guidelines to medical and clinical research[41]; and

Whereas, There is significant variation in guidance from Institutional Review Boards on the inclusion of research participants with LEP[42]; and

Whereas, Inequitable representation in clinical and medical research is costly to both individual health and societal prosperity, as reinforced by a recent report which estimated that total elimination of health inequities in diabetes, heart disease, and hypertension has a value of approximately $11 trillion[43]; and

Whereas, The American Medical Association recognizes the importance of utilizing language interpreters as a means for improving the quality of care provided to patients with LEP in policies H-160.924, D-300.976, H-295-879, and H-160.924; therefore be it

RESOLVED, That our AMA supports the use of language interpreters in research participation to promote equitable data collection and outcomes; and be it further

RESOLVED, That our AMA encourages research institutions to budget for the use of language interpreters in medical and clinical research proposals; and be it further

RESOLVED, That our AMA collaborates with the American Society for Physicians in Clinical Research to encourage relevant stakeholders to develop guidelines for the appropriate implementation of language interpreters in medical and clinical research.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

2.1.1 Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.
The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

7.1.2 Informed Consent in Research
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will. Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.
A valid consent process includes:
(a) Ascertaining that the individual has decision-making capacity.
(b) Reviewing the process and any materials to ensure that it is understandable to the study population.
(c) Disclosing:
(i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
(ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
(iv) the likelihood of therapeutic or other direct benefit for the participant;
(v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
(vi) the nature of the research plan and implications for the participant;
(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
(d) Answering questions the prospective participant has.
(e) Refraining from persuading the individual to enroll.
(f) Avoiding encouraging unrealistic expectations.
(g) Documenting the individual's voluntary consent to participate.
Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:
(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.

(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
(j) There is potential for the individual to benefit from the study.
In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.
(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Support for Standardized Interpreter Training D-300.976
Our AMA: (1) encourages physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services"; and (2) will work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 29
(A-23)

Introduced by: James Garcia, Sidharth Nayak, Montgomery Smith, Shriya Veluri, John Hoverson, Jonathan Dao, Abram Qiu, Long School of Medicine

Subject: Addressing Augmented Intelligence in Medical Education

Sponsored by: Association of Native American Medical Students, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Augmented intelligence (AI), otherwise known as artificial intelligence (AI), is a rapidly growing branch of computer science capable of analyzing complex medical data, and it has been suggested by practicing physicians that AI should be integrated into medical education[1-2]; and

Whereas, Multiple studies cited in a systematic review indicated that AI integration into medicine is imminent and that there is a need for medical professionals to utilize AI tools in such a way as to ensure the safe and appropriate integration of AI into practice[1]; and

Whereas, AI is expected to play increasingly significant roles in medical practice, but only 6.0% of medical students feel prepared to inform patients on the use of AI in their care, and more than 96% of students feel their medical education is inadequate in teaching the “knowledge and skills related to artificial intelligence applications”[3-4]; and

Whereas, AI is currently being applied to aspects of medical practice that medical students are refining their skill set in, including processing large amounts of data, optimizing diagnostic algorithms, and generating a differential diagnosis, such as studies where AI performed on par with dermatologists in dermatologic condition recognition,[5]; and

Whereas, The full breadth of medical knowledge exceeds the capacity of the human mind, and the utilization of AI is a potential resource to assist medical practitioners in accessing, organizing, and applying information, otherwise indicated as “knowledge management”[1,6]; and

Whereas, A systematic review noted that most studies indicated a need for AI integration into undergraduate medical education (UME) to facilitate the skills necessary for working with and managing AI in clinical practice[1]; and

Whereas, A systematic review emphasized the impact of AI on health care emphasized the importance of integrating AI into medical education, and identified that the AMA “did not provide specific curricular recommendations” on this subject[1]; and

Whereas, Multiple studies in a systematic review indicated examples of positive impacts of AI integration in health care and UME, including the expansion of physician's decision-making processes and the utilization of AI in processing large amounts of data, such as interpreting medical imaging[1]; and

Whereas, The integration of AI into UME has been attempted by a few medical institutions, and studies of the implementation do not indicate a definitive method to maximize effectiveness in training or education but still indicate the importance of AI integration into UME[1,3,6-9]; and

Whereas, Despite the integration of AI into UME being encouraged by the American Medical Association (AMA) in policy H-295.857, current policy does not explicitly encourage the development of learning objectives regarding AI integration into UME; and

Whereas, AMA policy H-295.857 touches on concepts that ought to be covered by medical education curriculum but does not address education on the legal and ethical limitations, the benefits of and limitations of application, the risks of utilizing AI systems, nor the fundamentals of the statistical foundation to AI application; and

Whereas, A fundamental understanding of the statistical foundation to AI application is critical to the appropriate application and utilization of AI tools[1]; and

Whereas, Research suggests that AI integrated UME curricula learning objectives should focus on knowledge capture rather than retention, "collaborating with and management of AI applications," "understanding of probabilities" associated with AI tools, and understanding "the application, benefit, limitations, and risks of AI systems"[1,6,8,10]; and

Whereas, A recent study has shown the benefits of providing multidisciplinary AI workshops to improve medical students' educations on AI, including an increase in multidisciplinary collaboration and addressing concerns with AI[11]; and,

Whereas, Studies suggest that AI integrated curricula could include online modules, small-group sessions and lectures, opportunities to work directly with AI tools, and interactive case-based workshops to teach students AI fundamentals[1,10,12]; and

Whereas, Potential negative consequences of improperly regulated integration of AI into medical practice include unintended fitting to confounding variables, accidental inclusion of discriminatory bias, and overgeneralization of limited test data to untested populations[13]; and

Whereas, As the field of artificial intelligence within medicine is rapidly growing, there is a wide variety of research that needs to be conducted regarding how AI can be best integrated into current medical practice to maximize its added value while mitigating its potential negative consequences; and

Whereas, There is a need for medical institutions to partner with faculty showing expertise in AI applications in both clinical and non-clinical varieties to effectively teach these concepts to medical students[14]; and

Whereas, AMA policy H-295.857 promotes the inclusion of AI-educated non-clinical faculty into hospitals but it does not promote the inclusion of additional clinical faculty who have had AI education[10]; and

Whereas, Despite the integration of AI into UME being encouraged by the American Medical Association (AMA) in policy H-295.857, current policy is ambiguous when referencing "AI instruction in medical education" and does not clarify if it is referring to AI-delivered medical education or education about the usage of AI in medicine; and

Whereas, A study has noted that the usage of AI in the delivery of medical education may provide benefits including but not limited to "immediate feedback, enhancement of problem based learning with learning guided theory, identifying and responding to gaps in students' knowledge, reduced need for teacher supervision, less costs and no potential harm to patients"[15]; and

Whereas, A study has indicated that a multidisciplinary approach including clinical faculty with AI expertise is vital to the implementation of clinically relevant AI learning for students, preventing a "siloed approach" that may lead to "clear clinical targets going unnoticed"[10]; and

Whereas, Despite the integration of AI into UME being encouraged by the American Medical Association (AMA) in policy H-295.857, current policy does not indicate that medical students and educators be held accountable to meet the standards of professionalism while participating in AI integrated curriculum; and

Whereas, AMA policy 11.2.1 mentions that AI technology must be held to a high standard of validation and data quality, the policy does not address that medical students be held accountable for utilizing AI technology; and

Whereas, AMA policy 11.2.1 indicates that physician-leaders are held accountable to meeting conditions for professionalism in health care systems, including the use of AI technology; however, the policy does not address holding medical students accountable; and

Whereas, AMA policy D-295.983 mentions promoting professionalism in medical education, but the policy does not address the integration of novel technology, such as AI, into medical education and how those utilizing the technology should be held accountable for its application; and

Whereas, Despite the integration of AI into UME being encouraged by the American Medical Association (AMA) in policy H-295.857, current policy does not encourage institutions and programs to consider the additional workload placed on institutions, academic leaders, and physicians due to the AI integration into UME ; and

Whereas, Physician educators are exhibiting an increase in burnout from excessive workloads, clerical duties, and exposure to high work stress[16-17]; and

Whereas, The integration of AI into medical curriculum will place additional administrative duties on medical educators and physicians; therefore be it

RESOLVED, That our AMA amend the existing policy H-295.857 Augmented Intelligence (AI) in Medical Education by addition and deletion as follows:

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

~~(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;~~

(3) research regarding the effectiveness of AI-delivered medical education on learning and clinical outcomes;

(4) research regarding how to effectively integrate education over the integration of AI into medicine;

~~(4)~~(5) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

~~(5)~~(6) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

~~(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;~~

(7) the study of disparities regarding access to and education on AI in medicine;

~~(7)~~(8) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

~~(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;~~

(9) the study of how AI may perpetuate or affect disparities in health care;

~~(8)~~(10) institutional leaders and academic deans to proactively accelerate the inclusion of non-clinicians, such as data scientists and engineers, as well as AI-educated physicians, onto their faculty rosters in order to assist learners in their understanding and use of AI; ~~and~~

~~(9)~~(11) close collaboration with and oversight by practicing physicians in the development of AI applications~~.~~;

(12) institutions and programs to be deliberative in developing comprehensive learning objectives and educational opportunities regarding augmented intelligence integrated curriculum;

(13) institutional leaders and academic deans hold students and educators participating in AI integrated curriculum accountable to meeting the conditions for professionalism in health care systems; and

(14) institutions and programs consider how the integration of AI will affect the workload of medical educators.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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

11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations and the profession should:
(a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
(c) Ensure that all such tools:
    (i) are designed in keeping with sound principles and solid scientific evidence.

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

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

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

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

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

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

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

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

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

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

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

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

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

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

AMA Principles of Medical Ethics: I,II III,V

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

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;

b. is transparent;

c. conforms to leading standards for reproducibility;

d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of healthcare AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
BOT Rep. 41, A-18

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
BOT Rep. 21, A-19; Reaffirmation: A-22

Fostering Professionalism During Medical School and Residency Training D-295.983

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 30
(A-23)

Introduced by: Victoria Panwala, Washington State University School of Medicine; Carson Hartlage, University of Cincinnati College of Medicine; Matinder Dhillon, CHSU-COM; Amanda Block, Burnett School of Medicine at TCU; Catriona Hong, University of Connecticut School of Medicine; Whitney Stuard, UTSW; Elizabeth Abrams, Haley Klimaszewski, The Ohio State College of Medicine; Julia Versel, Loyola University Chicago Stritch School of Medicine

Subject: Advocating for methadone maintenance therapy dispensation in community pharmacy settings

Sponsored by: Region 5, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Opioid Use Disorder (OUD) has dramatically increased in the United States in the past two decades with 4% of the adult U.S. population misusing opioids[1,2] and 3.52% of adolescents reporting prescription opioid misuse[1-4]; and

Whereas, As of 2020, overdose deaths have increased by more than 8 times since 1999[5]; and

Whereas, Despite a 44% decrease in opioid prescriptions and increased the use of state prescription drug monitoring programs, the number of overdose deaths more than doubled from 2011 to 2020[6]; and

Whereas, The estimated annual cost of opioid use disorder and fatal opioid overdose in the United States is $1.02 trillion, the majority of which is due to reduced quality of life and value if list lost[7]; and

Whereas, Medication for Opioid Use Disorder (MOUD) has been shown to result in improved clinical outcomes for those who abused opioids by decreasing the risk of overdose, drug use, criminal behavior, needle sharing, human immunodeficiency virus risk, and improved quality of life,[,] as well as increased treatment retention [8-11]; and

Whereas, The Food and Drug Administration has approved the use of MOUD, and MOUD has been shown to significantly reduce the need for inpatient treatment overall[12]; and

Whereas, The National Institutes of Health states that “The safety and efficacy of medically assisted treatment has been unequivocally established” and should therefore be utilized when indicated in OUD[13,14]; and

Whereas, Medications shown to effectively treat OUD include the following: buprenorphine, methadone, and extended-release naltrexone[14]; and

Whereas, When compared to non-pharmacological treatments and naltrexone, only buprenorphine or methadone treatment were associated with a reduced risk of overdose and could reduce opioid deaths in vulnerable populations by as much as 40-60%[15]; and

Whereas, U.S. counties with high rates of opioid overdose mortality are also found to be lacking in capacity to provide medication for OUD[16]; and

Whereas, Only 20% of people in the U.S. with OUD receive opioid agonist therapy like methadone, and treatment is particularly underutilized among vulnerable groups including native Hawaiians/Pacific-Islanders/Asian-Americans, the uninsured, African-Americans, and adolescents[17]; and

Whereas, Black and Latino patients are generally 20% to 35% less likely to complete OUD treatment and have up to 30% lower odds of receiving MOUD compared to their White counterparts[18]; and

Whereas, In adolescent populations, only 14% of patients aged 16-17 years old with OUD receive medication treatment[19]; and

Whereas, Federal law requires opioid agonist therapies like methadone be dispensed only through a Substance Abuse and Mental Health Services Administration-certified opioid treatment program (OTP)[12]; and

Whereas, In 2019, 46.4% of all counties and 71.2% of rural counties lacked a publicly-listed MOUD provider[2], and limited methadone treatment capacity exacerbates racial, gender, and geographic disparities in access to OUD treatment[16,20,21]; and

Whereas, In rural areas, patients face disproportionately affected by disparities in geographic access to MOUD, with longer drive times to an OTP, 48.4 minutes on average compared to only 16.1 minutes for rural residents, compared to community pharmacies, 4.4 minutes on average[22-24]; and

Whereas, U.S. pharmacists working in community pharmacies have the ability to dispense methadone, but are only permitted to do so for the treatment of pain and not for the treatment of OUD[25]; and

Whereas, Greater than 90% of Americans live within 2 miles of a community pharmacy, and proximity to treatment is associated with increased treatment retention for people with OUD[26-28]; and

Whereas, Retention in MOUD treatment, including methadone treatment, is associated with significant reductions in the risk for all-cause and overdose mortality in people dependent on opioids[29]; and

Whereas, Take-home policies for opioid agonist treatment like methadone require patients to return to the clinic on a daily or near-daily basis, introducing additional barriers to treatment retention[30]; and

Whereas, Legal research from Pew Trusts shows that the Drug Enforcement Administration is legally able to permit pharmacy dispensation of methadone for the treatment of OUD without

additional authorization from Congress, as the agency's regulations are more restrictive than current law[31]; and

Whereas, Community pharmacy-based dispensation of methadone maintenance therapy for OUD has been legal for years in the United Kingdom, Canada, and Australia[20,32]; and

Whereas, Multiple pilot studies of OTP prescribing and community pharmacy-based dispensation of methadone maintenance therapy for opioid use disorder have demonstrated its feasibility and acceptability in the United States[33-36]; and

Whereas, Bipartisan bills were introduced in both chambers of Congress that would allow methadone to be dispensed at local pharmacies with a prescription from an addiction medicine physician[37]; therefore be it

RESOLVED, That our AMA support the ability of OTP clinicians, physicians holding board certification in addiction medicine or addiction psychiatry, and other appropriately trained physicians such as primary care physicians to prescribe methadone for opioid use disorder that can be dispensed through a pharmacy for individuals for unsupervised use; and be it further

RESOLVED, That our AMA amend Policy D-95.961 by addition and deletion to read as follows:

> **Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings D-95.961**
> Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) ~~supports further research to help define the population of patients who may be safely treated with~~ advocate for the provision of methadone maintenance treatment via office-based treatment, including primary care; ~~and~~ (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment; and (4) will advocate for methadone maintenance therapy doses to be dispensed in a community pharmacy setting for patients who are receiving methadone maintenance therapy treatment at a licensed Opioid Treatment Program.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings D-95.961
Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) supports further research to help define the population of patients who may be safely treated with methadone maintenance treatment via office-based treatment, including primary care; and (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment.

Medical Direction of Methadone Treatment H-95.977
Our AMA urges that the operation of methadone treatment programs be under the direction of physicians who are knowledgeable and competent in the treatment of addiction.

Methadone Maintenance in Private Practice H-95.957
Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further;

(2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;

(3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;

(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained

and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and

(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD) H-95.913
1. Our AMA affirms: (a) that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder; and (b) that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including but not limited to methadone and buprenorphine.
2. Our AMA strongly encourages the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including but not limited to methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student’s treatment plan includes MOUD.
3. Our AMA will survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice.

Table of Contents

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 31
(A-23)

Introduced by: Chayton Fivecoat, Johan Harris, Cole Sabinash, Wayne State University School of Medicine; Kristofer Jackson, University of Toledo College of Medicine and Life Sciences

Subject: Encouraging the Transition from Artificial Turf to Natural Grass Surfaces for Athletic Use

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Natural grass and artificial turf are two common athletic surfaces for outdoor athletic events; and

Whereas, Artificial Turf was first used in the United States in 1966 in the Houston Astrodome, the former home of Major League Baseball's Houston Astros, because the stadium's glass roof was painted black to help outfielders field fly balls, which led to the stadium being unable to grow grass because the sunlight could no longer reach the field[2]; and

Whereas, There are more than 11,000 artificial turf fields currently in the United States[3]; and

Whereas, Approximately 56.1% of children and adolescents aged 6-17 participated in athletic activities, potentially on artificial turf, with that number increasing year over year; and

Whereas, Approximately 276,365 NCAA athletes participated in sports that could practice or play on artificial turf surfaces during the 2018-2019 athletic seasons[5]; and

Whereas, There are 1696 players on NFL active rosters, 811 MLS soccer players, and 906 MLB players that play and practice on artificial turf surfaces each year[6, 7, 8]; and

Whereas, Total costs for the installation of artificial turf (ie equipment, supplies, and labor costs) range from $600,000- $1,000,000[9]; and

Whereas, Total costs for natural grass range from $50,000-$600,000 to install[9]; and

Whereas, Natural grass only requires at least $4,000 and 250 hours of labor, to maintain per year while Artificial turf requires at least $6,000 and 375 hours of labor to maintain[9]; and

Whereas, Artificial turf has a maximal lifespan of 10 years and must be completely replaced at the end of its lifetime costing at least $500,000, while natural grass does not have a maximal lifespan, and can be utilized for much longer based on quality of upkeep[9]; and

Whereas, When limited to the same lifespan and standard of playability, natural grass is cheaper to maintain and install than its artificial turf counterparts ($53.41/$m^2$ vs. $75.29/$m^2$)[9,10]; and

Whereas, Even though natural grass requires more water to produce and maintain than artificial turf (7926 gallons/m^2 vs 1926 gallons/m^2) natural grass is still cheaper to maintain even in the driest areas in the country[9, 10]; and

Whereas, The Massachusetts Toxic Use Reduction Institute, found that “in nearly all scenarios, the full life-cycle cost of natural turf is lower than the life-cycle cost of a synthetic turf field for an equivalent area”[11]; and

Whereas, Artificial turf generates a larger carbon footprint, up to 1500 CO_2e tonnes, during the manufacturing and degradation process and contributes to contaminated water and microplastic pollution[12]; and

Whereas, The average soil organic carbon sequestration rate for natural grass was found to be up to 127.1 g C/m2/year, and can lead to a net positive carbon system for up to 199 year.[10,12]; and

Whereas, Of the 306 known components of crumb rubber (the major component of artificial turf pellets) 52 are known, presumed, or suspected carcinogens[3]; and

Whereas, Artificial turf is found to have lower shock absorption, higher friction coefficients, creates a higher magnitude of torque, which each directly correlate to higher incidence of injury in the average athlete[13]; and

Whereas, It has been shown that amongst Major League Soccer players the rate of Achilles injury was twice as high on turf as it was grass and the rate of ankle fracture was 6 times as high on turf compared to grass[14]; and

Whereas, Total cost of operative management of Achilles tendon rupture costs on average of $13,936[15]; and

Whereas, It has been shown that the rate of PCL tears, in all three divisions of NCAA football, was almost 3 times greater on artificial turf than on natural grass and ACL tears occurred 1.6 times as often on artificial turf than on natural grass[16]; and

Whereas, The median total health care utilization cost per ACL tear and reconstruction is $13,403.38[17]; and

Whereas, Concussions resulting from contact with the ground in both collegiate and high school football were disproportionately associated with playing on artificial turf and these concussions were also associated with greater severity on turf[18]; and

Whereas, It has been shown that high school athletes were 58% more likely to sustain a lower extremity, upper extremity, or torso injury while on turf compared to natural grass surfaces[19]; and

Whereas, It has been shown that overall, men and women are removed from play due to “non-season ending” injuries longer when their injury occurred on artificial turf than the same injuries sustained on natural grass surfaces[20]; and

Whereas, Playing on artificial turf in NFL games results in a 16% increase in lower extremity injury per play compared to playing on natural grass surfaces[21]; and

Whereas, With recent developments in agricultural and architectural technology, natural grass has been found to grow underneath domed stadiums[22]; and

Whereas, In 2008, the Houston Astros reverted back to utilizing natural grass in their domed stadium for the safety of their athletes; and

Whereas, According to a letter from the National Football League’s Player Association (NFLPA) “The NFLPA is advocating for teams to convert artificial practice and game fields to natural grass fields” due to the increased risk of both contact and non-contact joint injuries[24]; and

Whereas, Despite the outcry of athletes in the name of player safety, NFL owners have made recent shifts to artificial turf fields in their stadiums in order to support concerts and other events in an effort to increase their profits[25]; and

Whereas, The AMA is committed to athletes' safety and consistently advocates for proper equipment, safety guidelines, and training for coaches with promises to assist local, state, and federal efforts to eliminate concussions in contact sports; and

Whereas, Transitioning from artificial turf to natural grass surfaces falls directly in line with H-470.956 and supports athletic facilities in the “avoidance of inappropriate surfaces”; therefore be it

RESOLVED, That our AMA recognizes that the installation and maintenance of artificial turf is more environmentally detrimental than natural grass fields; and be it further

RESOLVED, That our AMA recognizes that those participating in athletic activities on artificial turf are at an increased risk of injury compared to those performing the same activities on well-maintained natural grass.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Reduction of Sports-Related Injury and Concussion H-470.954
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE). (CSAPH Rep. 3, A-15Appended: Res. 905, I-16)

Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959
1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.
3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.
4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their

participation in sports. (Res. 910, I-10Reaffirmed: BOT Rep. 9, A-14Modified: CSAPH Rep. 3, A-15, Modified: BOT Action in response to referred for decision: Res. 409, A-17)

Soccer Injuries H-470.960
Our AMA recognizes the problem of injuries in soccer and encourages additional studies into the incidence of soccer-related injuries and methods to reduce those injuries. (Sub. Res. 404, A-09Reaffirmed: CSAPH Rep. 3, A-15)

Injuries in Cheerleading H-470.956
Our AMA: (1) supports the designation of cheerleading as a sport; and (2) recognizes the potential dangers of cheerleading, including the potential for concussion and catastrophic injury, and supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as 'sports' by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts

Evaluating Green Space Initiatives H-470.953
Our AMA supports appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 32
(A-23)

Introduced by: Manasvi Khullar, Caitlin Hall, Grace Hwang, Himani Aligireddy, Touro University California; Sweta Parjia, UCSD; Jenna Gage, UTMB

Subject: Addressing Increasing Microplastics Pollution in Water and the Health Effects of Plastic on Human Health

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Half of all plastic ever produced was manufactured in the last 13 years[1]; and

Whereas, The breakdown of an estimated 5 billion metric tons of plastic in landfills and the environment, and the production of 400 million metric tons of plastic each year accounts for the constantly rising levels of plastics in the environment[2,3]; and

Whereas, Of the 14,000 tons of waste generated daily in US health care facilities, about 20% to 25% is plastic[4-6]; and

Whereas, 91% of plastics, including those used in health care, are not recycled and either reside in landfills or have infiltrated natural environments[4-6]; and

Whereas, There is minimal evidence of single-use plastic reducing healthcare-acquired infections[7-9]; and

Whereas, Plastic microfibers are particles of plastic less than 5 millimeters in diameter that originate from petroleum-derived compounds and are one of the dominant forms of microplastic pollution in the oceans[10]; and

Whereas, Plastic is ubiquitous in our world, ranging from personal care products to clothing, with 60% of textiles produced from synthetic material such as nylon and polyester[11]; and

Whereas, A survey of practices adopting alternatives to single-use plastics in 332 hospitals identified considerable savings[4]; and

Whereas, Textiles made of synthetic fibers shed plastic microfibers throughout their life cycle including during production, use, washing, and after their disposal, contributing to a wastewater plastisphere and 35% of microplastics found in oceans[11-13]; and

Whereas, Microfibers are the most common anthropogenic contaminant in water used to wash synthetic fabrics and textiles, shedding around 9.6 mg to 1,240 mg/kg of textile per wash[14]; and

Whereas, Per- and Polyfluoroalkyl Substances (PFAS) are known as “forever chemicals” and come from waterproof clothing, which then spreads into our drinking water[15,16]; and

Whereas, AMA policy H-135.916 currently supports regulation of PFAS and the Environmental Protection Agency is currently seeking regulatory action in this space[17]; and

Whereas, The largest contributors to microplastic intake are via drinking water and through inhaling and ingesting dust particles[18]; and

Whereas, The average United States resident consumes 74,000 and 121,000 particles of microplastics annually by ingestion and inhalation alone[19]; and

Whereas, The effects of microplastics include provoking the immune system and stress response, and reproductive and developmental toxicity[20]; and

Whereas, Microplastics can translocate across living cells to enter the lymphatic and circulatory system, accumulate in secondary organs, lead to dose dependent increases in myeloperoxidase levels, impair the compliment system, increase IgA levels, and/or increase upregulation in T-cell receptors amongst various vertebrate species[18, 19, 21, 22]; and

Whereas, Microplastic particles can disrupt the endocrine function of marine animals and amphibians by destruction of the thyroid gland and inhibition of endocrine regulatory signaling pathways[23]; and

Whereas, Exposure to microplastics in mice altered the expression of neuronal genes, synaptic proteins, and increased neuroinflammation in the hippocampus[24]; and

Whereas, Microplastics have been found in human blood, placenta, and human lung tissues[25-28]; and

Whereas, Microplastics may be considered a vector for the spread of disease[29,30]; and

Whereas; Plastic pollution's negative effects on human health disproportionately impact marginalized communities such as women, racial and ethnic minorities, children, and workers that live near plastic production facilities[31]; and

Whereas, The estimated costs of plastic production's harm on human health in 2015 exceeded $250 billion[31]; and

Whereas, Current microplastic removal strategies currently include membrane filtration (such as waste water treatment plants), adsorption methods, magnetic separation, coagulation treatments, chemical oxidation, and biodegradation[32]; and

Whereas, Wastewater treatment plants (WWTP) are most widely used to decontaminate water from microplastics but do not currently remove particles that are micro- or nano-sized, causing the creation of a plastic biofilm that nourishes antibiotic-resistant bacteria, bacterial pathogens, and antibiotic resistance genes[12,33]; and

Whereas, WWTP use wastewater sludge, a byproduct of the filtration process, as fertilizer for soil, potentiating the effects of plastic in natural environments[34]; and

Whereas, Laundry machine microplastic removal traps can remove up to 90% of polyester fibers and 46% of nylon fibers[35]; and

Whereas, Current gaps in research identify varying levels of effectiveness of WWTP microplastic removal processes and suggest further research is needed[36-39]; and

Whereas, France has felt the urgency of this situation and mandated that microplastic filters be introduced to washing machines by 2025[40]; and

Whereas, Australia has taken action to require microfiber filters in all new washing machines by 2030[41]; and

Whereas, The state of California, the world's 4th biggest economy, has introduced a bill to require washing machines to include a microplastic filter[42, 43]; and

Whereas, Current AMA policies H-135.929, H-135.916, D-135.993 recognize certain microplastics may affect human health and the environment; and

Whereas, Current AMA policy, H-135.973 encourages relevant stakeholders to take responsibility and stewardship of improving the environment; therefore be it

RESOLVED, That our AMA support efforts by the US Environmental Protection Agency to encourage relevant stakeholders to research efforts to reduce microplastic pollution, including but not limited to wastewater treatment plants and laundry machine removal filters; and be it further

RESOLVED, That our AMA-MSS amend pending transmittal "Research Plastic Use in Medicine" by the addition as follows:

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 research into the reduction of single-use plastic in medicine; (15) encourages research on the effects of microplastics on human health; (16) encourages research into the reduction methods of microplastic pollution (17) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (18) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (19) encourages expanded funding for environmental research by the federal government; and (20) encourages family planning through national and international support.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
CSA Rep. G, I-89Amended: CLRPD Rep. D, I-92

Banning Plastic Microbeads in Personal Care Products H-135.929

Our AMA supports local, state, and federal laws banning the sale and manufacture of personal care products containing plastic microbeads.
Res. 916, I-15

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health H-135.916

Our AMA: (1) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.

Contamination of Drinking Water by Pharmaceuticals and Personal Care Products D-135.993

Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.
Res. 403, A-06Modified: CSAPH 01, A-16

AMA-MSS Pending Transmittal #230 RESEARCH OF PLASTIC USE IN MEDICINE
RESOLVED, That our AMA amend by addition as follows:

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; <u>(14) encourages research into the effects of microplastics on human health;</u>(14<u>5</u>) encourages physician educators in medical

schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (1~~5~~6) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (1~~6~~7) encourages expanded funding for environmental research by the federal government; and (1~~7~~8) encourages family planning through national and international support.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 33
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Lyndsay Kandi, University of Arizona: College of Medicine (Tucson); Jacob Greene, UC San Francisco School of Medicine; Hailey Baker, University of Minnesota Medical School; Syeda Akila Ally; University of Illinois College of Medicine Chicago; Brandon Butcher, University of Minnesota Medical School Ida Vaziri, UT Health San Antonio; Whitney Stuard, UT Southwestern; Anna Klunk, Philadelphia College of Osteopathic Medicine

Subject: Racial Misclassification

Sponsored by: Region 1, Region 2, Region 3, Region 6, Student Osteopathic Medical Association, Association of Native American Medical Students, PsychSIGN, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The National Center for Health Statistics maintains a National Death Index (NDI), a centralized database of death record information on file in state vital statistics offices[1-2]; and

Whereas, These data can be linked to databases maintained by agencies like the Centers for Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid Services to increase the availability of information on an individual's cause of death[1-5]; and

Whereas, A key limitation of these vital statistic data is the misclassification of race and ethnicity on death certificates and in other databases (e.g., inaccurate from minority identification to white) , limiting the quality and applicability of data available for racial and ethnic minority populations experiencing health disparities[6-7]; and

Whereas, Populations more likely to be misclassified on their death certificates include, but are not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native Hawaiians and Other Pacific Islanders (NHPI)[6,8-13]; and

Whereas, A retrospective linkage of regional records maintained by the Indian Health Service and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-cause mortality in the AI/AN population[6]; and

Whereas, An updated version of the National Longitudinal Mortality Study (1999-2011 decedents versus 1990-1998 decedents) found that racial misclassification remained high at 40% for the AI/AN population, improved, from 5% to 3%, for the Hispanic population, and from 7% to 3% for the Asian or Pacific Islander (API) population[14-15]; and

Whereas, Racial misclassification on death certificates is compounded by missing or incorrect race and ethnicity data in other databases, such as those maintained by federal health programs, hospital systems, and related entities[15-19]; and

Whereas, A 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and Puerto Rico) as non-Hispanic white[20]; and

Whereas, A 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest Tribal Registry and Oregon and Washington hospital discharge datasets increased the ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in Oregon and by 18.1% in Washington[21]; and

Whereas, According to the United States Centers for Disease Control and Prevention, more AI/AN patients are misclassified as another race in cancer registry records than patients in other racial groups, likely from one group to identification as non-Hispanic white[22-23]; and

Whereas, A 2021 prospective observational study of patients admitted to an urban Level 1 trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9%) had inaccurately recorded ethnicity in the trauma registry[24]; and

Whereas, Decedent race and ethnicity may be subject to bias as a 2018 project by the National Consortium for Urban Indian Health found that 48% of surveyed funeral directors were recording an individual's race on death certificates by observation of the individual rather than asking their next of kin[9,25]; and

Whereas, Mortality-related research data, combined with other clinically-based registries, is a fundamental tool for establishing public health priorities (e.g., advocacy, resource allocation, stakeholder engagement) at the local, state, tribal and federal level and is an important part of Indigenous Data Sovereignty (H-460.884)[26]; therefore be it

RESOLVED, Our AMA amend Improving Death Certification Accuracy and Completion H-85.953 by addition as follows:

Improving Death Certification Accuracy and Completion H-85.953

1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.

2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv)

included as part of in-service training programs for nursing homes, hospices and geriatric physicians.

3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.

4. Our AMA further: (a) supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

AMA Race/Ethnicity Data D-630.972
1. Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile.
2. Our AMA will: (a) adopt racial and ethnic demographic data collection practices that allow self-identification of designation of one or more racial categories; (b) report demographic physician workforce data in categories of race and ethnicity whereby Latino, Hispanic, and other identified ethnicities are categories, irrespective of race; (c) adopt racial and ethnic physician workforce demographic data reporting practices that permit disaggregation of individuals who have chosen multiple categories of race so as to distinguish each category of individuals' demographics as alone or in combination with any other racial and ethnic category; and (d) collaborate with AAMC, ACGME, AACOM, AOA, NBME, NBOME, NRMP, FSBM, CMSS, ABMS, HRSA, OMB, NIH, ECFMG, and all other appropriate stakeholders, including minority physician organizations, and relevant federal agencies to develop standardized processes and identify strategies to improve the accurate collection, disclosure and reporting of racial and ethnic data across the medical education continuum and physician workforce.

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were

developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity, and preferred language.

Federal Block Grants and Public Health H-440.912

1. Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
2. Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
3. Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public healthsystem; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
4. Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
5. Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

Improving Death Certification Accuracy and Completion H-85.953

1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.
2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.
3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.

AMA-MSS I-22 Resolution 001: Tribal Public Health Authority (Pending Transmittal)

RESOLVED, Our AMA advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities; and be it further

RESOLVED, Our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and be it finally

RESOLVED, Our AMA encourages the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 34
(A-23)

Introduced by: Alec Calac, UCSD School of Medicine; Brianna Ma, California University of Science and Medicine; Zach Dunton, University of Wisconsin School of Medicine and Public Health; Agnieszka Mynarska, Chicago College of Osteopathic Medicine, Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Jona Kerluku, Carle Illinois College of Medicine; Ryan Sorensen, BCM; Shannah Avila, UNTHSC-Texas College of Osteopathic Medicine; Whitney Stuard, UT Southwestern Medical Center; Scott Spivey-Provencio, UT Austin Dell Medical School; Julia Houshmand, Miami Miller School of Medicine; Joey Ballard (primary author) and Jara Crawford, Indiana University School of Medicine; Shad Yasin, Rutgers New Jersey Medical School; Taylor Glassman, RWJMS; Donald Bourne, University of Pittsburgh; Afra Trinidad, Rutgers Robert Wood Johnson Medical School; Krishna Channa, Amanda Kahn, Catriana Hersey, Jaelle Hersey, Kaitlyn Petitpas, Dean Kim,Catriona Hong UConn School of Medicine; Jane Branch, Tufts University School of Medicine

Subject: Improving Nonprofit Hospital Charity Care Policies

Sponsored by: Region 2, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Nonprofit hospitals make up greater than half of all hospitals nationwide, representing a significant source of the healthcare system[1]; and

Whereas, The value of nonprofit hospital tax exemption in 2020 was an estimated $28 billion, a 45% increase from 2011[2]; and

Whereas, An analysis from 2019 showed that a subset of nonprofit hospitals in Texas saved $10.7 million on average annually as a result of their tax exempt status[3]; and

Whereas, Nonprofit hospitals must fulfill community benefit requirements to maintain tax exempt status, which include costs of charity care, health professions education, health services research, subsidized health services, community health improvement activities, and cash or in-kind contributions to other community groups[4,5]; and

Whereas, In 2021, compared to government and for-profit hospitals, nonprofit hospitals spent about half of the amount for every $100 of their budget for charity care, suggesting that many hospital charity care provisions were not aligned with their charity care obligations[6]; and

Whereas, There is no federal standard specifying requirements about patient eligibility for charity care, as nonprofit hospitals internally define which patient populations can qualify for assistance, often excluding noncitizens[7]; and

Whereas, Qualifying patients must apply within 240 days that the first post-discharge billing statement is provided to receive financial assistance[8]; and

Whereas, Ten states have established eligibility requirements ensuring that hospitals not only offer financial assistance programs, but also effectively communicate these policies and application procedures to patients[9,10]; and

Whereas, Greater than 50% of the time, nonprofit hospitals have charged patients who met eligibility criteria to receive charity care despite the requirement for hospitals to make their charity care policies "widely publicized" and to notify community members about them[7,11,12]; and

Whereas, In 2019 nonprofit hospitals billed at least $2.7 billion to patients who qualified for charity care[12]; and

Whereas, Patients cannot directly seek redress in instances of noncompliance, and the IRS is the only entity that can enforce compliance of nonprofit hospitals to provide financial assistance[9]; and

Whereas, Health economists have suggested that increasing transparency by disclosing the charity-care-to-expense ratio and charity-care-to-benefit ratio of hospitals would allow for benchmarking of hospital compliance of charitable care and community benefit activities[3]; and

Whereas, A New York Times investigation reported a case of a large nonprofit hospital system training administrative employees not to ask about any eligibility criteria for charity care or mention available financial assistance programs when asking patients for payment[1]; and

Whereas, A 2021 study published in *JAMA Network Open* found that nonprofits made up 70% of hospitals that were suing patients for their unpaid medical debt from September 2019 to September 2020, which suggests that some hospitals are participating in "extraordinary collections actions" which is banned by the IRS 501(r) rule[13]; and

Whereas, Billing patients despite existing charity care policies and uneven eligibility across nonprofit hospitals contributes to medical debt[7,12]; and

Whereas, Medical debt is considered a social determinant of health, as it is may prevent seeking and receiving appropriate medical care[14,15]; and

Whereas, Medical debt is a substantial burden with more than 100 million people, including 41% of adults, dealing with debt, collectively totaling at least $195 billion[16]; and

Whereas, Medical debt is the most common cause of bankruptcy in the United States, accounting for more than 62% of all bankruptcies[17]; and

Whereas, Medical debt prevents patients from obtaining care due to cost and, more concerningly, allows them to be denied access to doctors or other providers due to unpaid bills[16]; and

Whereas, Medical debt has been shown to disproportionately affect underserved minorities including Black and Hispanic adults compared to white adults[16]; and

Whereas, Hospitals that sell medical debt off to collectors subject patients to wage garnishment and have the potential to negatively impact patients' credit scores[16]; therefore be it

RESOLVED, That our AMA support efforts that require nonprofit hospitals to notify and screen all patients, in a format reasonably appropriate to the abilities and understanding of the patient, for financial assistance according to their own eligibility criteria prior to billing; and be it further

RESOLVED, That our AMA support efforts to establish standards for nonprofit hospital financial assistance eligibility taking cost of living and other geographic factors into consideration; and be it further

RESOLVED, That our AMA support efforts to establish a reasonable timeframe allowing patients can apply retroactively for nonprofit hospitals financial assistance; and be it further

RESOLVED, That our AMA encourage research to identify nonprofit hospital noncompliance, defined as billing practices not in accordance with their own financial assistance policies; and be it further

RESOLVED, That our AMA encourages Centers for Medicare and Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Offsetting the Costs of Providing Uncompensated Care H-160.923

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2)

supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Appropriate Hospital Charges H-155.958

Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.

155.010MSS Opposition to Debt Litigation Against Patients
AMA-MSS will ask the AMA to encourage health care organizations to: (1) Manage medical debt with patients directly and consider several options, including assistance applying to coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before using third-party debt collectors, while avoiding those that harass debtors; (2) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patients' well-being; and (3) Make multiple attempts to reach and negotiate with patients before proceeding with litigation against patients or any other punitive actions and reserve litigation for patients who are able, but unwilling to pay. (MSS Res. 26, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 35
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Lyndsay Kandi, University of Arizona: College of Medicine (Tucson); Jacob Greene, UC San Francisco School of Medicine; Syeda Akila Ally, University of Illinois College of Medicine; Brandon Butcher, University of Minnesota Medical School; Ida Vaziri, UT Health San Antonio Long School of Medicine; Whitney Stuard, UTSW.

Subject: Indian Health Service Pharmaceutical Coverage

Sponsored by: Region 2, Region 3, Region 6, Association of Native American Medical Students, PsychSIGN, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The four primary federal health programs in the United States are the Veterans Health Administration, Indian Health Service (IHS), Medicaid, and Medicare[1]; and

Whereas, The IHS, an agency within the United States Department of Health and Human Services, is responsible for providing federal health services to 2.6 million American Indians and Alaska Natives (AI/AN) from 574 federally-recognized AI/AN Tribes and Villages in 37 states[2]; and

Whereas, The IHS oversees a comprehensive Indian/Tribal/Urban (I/T/U) healthcare system that includes but is not limited to facilities operated directly by the federal government, tribal entities, and urban-based organizations; and

Whereas, The IHS is not an entitlement program, such as Medicare or Medicaid, which guarantees benefits or payment for some type of service(s) after meeting specified eligibility criteria[3,4]; and

Whereas, The IHS is not an insurance program, nor is it an established benefits package, such as the health services provided to military service persons[5]; and

Whereas, The IHS is responsible for paying for medical and dental services provided to AI/AN patients at I/T/U facilities (Direct Care), as well as purchasing medical and dental services for AI/AN patients at non-I/T/U facilities (Purchased and Referred Care)[6]; and

Whereas, The IHS Direct Care and Purchased and Referred Care budgets are limited, resulting in a medical priority system for medical and dental services and an agency-designation as the payor of last resort[4,6]; and

Whereas, A payor of last resort is defined as an entity that pays after all other programs have been pursued for enrollment and payment[7]; and

Whereas, As payor of last resort, AI/AN patients seeking medical and dental services must exhaust all public and private health care funding (e.g., Medicaid, Medicare, private insurance) before they become eligible for IHS payment[7]; and

Whereas, Per capita annual health care expenditures for the IHS ($4,078 – direct patient care) greatly differ from other federal health programs: Medicare ($13,185), Veterans Health Administration ($10,692), and Medicaid ($8,109)[8]; and

Whereas, 22% of patients at federally-operated IHS hospitals and health centers were uninsured or underinsured in 2018[9]; and

Whereas, The IHS is more likely to be the health care payor for AI/AN patients who are uninsured or underinsured, especially if they receive care from an I/T/U facility located on a reservation[6,9]; and

Whereas, The IHS maintains an internal National Core Formulary and National Pharmacy and Therapeutics Committee (NPTC), which decides the basic standard of care drugs which must be carried by all federal IHS facilities to promote the parity, portability, quality, safety, convenience, and cost-effectiveness of pharmaceuticals provided to AI/AN patients[10]; and

Whereas, The IHS National Core Formulary establishes the "floor" for pharmaceutical coverage at federal IHS facilities, and does encourage Tribal and Urban facilities to add additional drugs to the local formulary, as needed, except in closed cases; and

Whereas, The IHS National Core Formulary does not maintain drug coverage parity with other federal health programs[10]; and

Whereas, In 2015, the IHS NPTC approved coverage of Plan B One-Step more than two years after a federal court ordered the United States Food and Drug Administration to approve Plan B as an over-the-counter drug for women of all ages without a prescription[11-12]; and

Whereas, IHS coverage of Plan B One-Step also came more than four years after a report from American Civil Liberties Union and Native American Community Board reported that over half of IHS facilities did not offer any kind of emergency contraception despite legal obligations to raise the physical, mental, social, and spiritual health of AI/AN patients to the highest level[13]; and

Whereas, In 2022, the IHS NPTC voted to add (1) testosterone (any formulation) and (2) estradiol (patch and parenteral formulations) to the IHS National Core Formulary despite 2017 consensus guidelines on gender-affirming medications from the Endocrine Society[14-15]; and

Whereas, Tribal leaders and AI/AN health policy advocates have stated that access to standard-of-care pharmaceuticals ("pharmacoequity") is an outstanding concern for IHS patients[16]; and

Whereas, The IHS NPTC has the sole authority to determine the contents of the IHS National Core Formulary and makes formulary decisions as a cost management tool, limiting oversight and availability of medications to patients[10]; and

Whereas, Using a formulary as a cost management tool likely undermines a physician's best medical judgment, especially when a broad range of effective therapeutics may be available for a disease (D-330.933); and

Whereas, The AMA supports public and private health insurance coverage and benefits coverage for a wide range of pharmaceuticals and services (e.g., H-185.950, H-185.995, H-370.963, H-425.979, H-185.963, D-5.996, H-185.936, H-425.974, H-185.929); and

Whereas, Formulary composition that respects physicians' autonomy and best practice is a key component of Medicare Part D Prescription Drug Program Statutory Requirements, requiring, "at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients." (D-330.933); and

Whereas, Existing Medicare D protected drug classes requires administrators of Medicare to include on their formularies all drugs in six categories or classes: 1) antidepressants; 2) antipsychotics; 3) anticonvulsants; 4) immunosuppressants for treatment of transplant rejection; 5) antiretrovirals; and 6) antineoplastics; therefore be it

RESOLVED, That our AMA will advocate to the U.S. Department of Health and Human Services that essential FDA-approved pharmaceuticals mandated for coverage by Medicare, Medicaid, Tricare, and the Children's Health Insurance Program programs should also be covered by the Indian Health Service.

RESOLVED, That our AMA will work with the Indian Health Service and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients, including:

i. antidepressants;
ii. antipsychotics;
iii. anticonvulsants;
iv. immunosuppressants for treatment of transplant rejection;
v. antiretrovirals;
vi. antineoplastics;

Fiscal Note: Minimal

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RELEVANT AMA AND AMA-MSS POLICY

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for AmericanIndians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or IndianHealth Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with

improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Medicaid Coverage for American Indian and Alaska Native Children D-350.992
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located.
Drug Formularies and Therapeutic Interchange H-125.991
It is the policy of the AMA:
(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.
(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.
(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.
(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.

(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;

(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 36
(A-23)

Introduced by: Jithin George, University of Rochester School of Medicine and Dentistry; Catriona Hong, University of Connecticut School of Medicine at Farmville; Tanvi Karmarkar, University of Missouri Kansas City School of Medicine; Samantha Pavlock, Florida State University College of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Udit Vyas, Indiana University School of Medicine; Brandon Parker, Florida State University College of Medicine; Wyatt Lanik, University of Nebraska College of Medicine; Matthew Linz, Rutgers New Jersey Medical School; Kaye Dandrea, University of New England College of Osteopathic Medicine – Biddeford; Caroline Sublett, University of Virginia School of Medicine; Abhishek Dharan, Paul L Foster School of Medicine at Texas Tech University Health Sciences Center El Paso; Nikhil Linaval, Keck SOM of University of Southern California - Los Angeles

Subject: Call for Minimum Standard Subway Ventilation Standards

Sponsored by: Region 2, Region 4, Region 5, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Air pollution exposures related to underground subway systems in the United States pose a significant and unique concern to human health due to the lack of ventilation[1]; and

Whereas, Commuters on average spend about 30 to 40 minutes in subway systems and are exposed to unhealthy levels of air pollutants emitted from various interior components as well as air pollutants carried by ventilation supply air[2]; and

Whereas, The primary pollutants inside these subway systems are particulate matter, often consisting mostly of heavy metals like Fe, Cr, Ni, Co, Mn, and Cd, with widths less than or equal to 2.5 microns (PM2.5), aromatic hydrocarbons, carbonyls, and airborne bacteria, which have shown increased morbidity and mortality burden due to association with cardiovascular and respiratory diseases[2]; and

Whereas, PM2.5 concentrations have been associated with health risks including but not limited to asthma, lung cancer, heart disease, myocardial infarction, stroke, type 2 diabetes, dementia, and loss of cognitive function[3,4]; and

Whereas, PM2.5 exposures have been shown to increase systemic inflammation which drives major health effects in cardiovascular, immune, and nervous systems and not just the respiratory system with unique effects observed in infant, adolescent, and pregnant populations[5]; and

Whereas, Longer exposure times to air pollutants have been shown to correlate with worse health outcomes[3]; and

Whereas, Particulate exposures underground have been shown in in-vitro studies to be more toxic than exposure to ambient or urban particulate, especially when considering reactive oxygen species production[3]; and

Whereas, Subway tunnel air pollution, particularly iron-based air pollutants, disproportionately affects individuals from low socioeconomic status[6]; and

Whereas, The majority of subway riders and employees belong to minority communities and subway employee spend the most time in and exposed to subway stations[7,8]; and

Whereas, In the United States the national average ambient, outdoor PM2.5 concentration was 8.4 ug/m^3 in 2021[9]; and

Whereas, The mean real-time PM2.5 concentrations in underground stations in the United States were found to be 779 +/- 249 μg/m^3 in New York and 548 +/- 207 μg/m^3 in Washington, DC, with measurements during rush hour traffic reaching up to 1700 ug/m^3[1]; and

Whereas, Health risks from high PM2.5 concentrations have been clearly demonstrated and no standard for PM2.5 concentrations for subway ventilation systems exist[10]; and

Whereas, Health impacts have been found from PM2.5 at low concentrations and the WHO has concluded that no concentration of PM2.5 has been identified to be low enough so as to not impact human health[10]; and

Whereas, Ambient air, as referenced in H-135.991, is legally defined by the Environmental Protection Agency as “that portion of the atmosphere, external to buildings, to which the general public has access,” and therefore, does not encompass subway train ventilation[11]; and

Whereas, Our AMA recognizes the importance of advocating for environmental air quality in policies H-135.969, H-135.99, H-135.998, H-135.973, H-135.939, H-135.979, H-135.991; however, these policies reference “environmental” air quality, which refers to outdoor, above-ground air rather than indoor ventilated air; and

Whereas, Current AMA policy 135.991 states specifically advocates for “national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health” but, does not include heavy metals that make up the majority of particulate matter found in subway systems; and

Whereas, The only AMA policy to reference indoor air quality is H-135.918, which pertains to the regulation of indoor air quality specifically in schools; and

Whereas, The AMA recently reaffirmed D-135.978 and offered support to new, lower EPA standards for ambient, outdoor PM2.5 concentration but these standards do not reflect indoor, unventilated, underground microenvironments like the US subway system; and

Whereas, Indoor air quality is regulated by the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and The National Institute for Occupational Safety and Health (NIOSH)[12,13,14]; therefore be it

RESOLVED, That our AMA will support further research on safe levels of particulate matter in subway systems; and be it further

RESOLVED, That our AMA supports the development of minimum ventilation standards for subway cars and tunnels in conjunction with relevant stakeholders such as the Centers for Disease Control and Prevention, the Environmental Protection Agency, The National Institute for Occupational Safety and Health, and the Occupational Safety and Health Administration.

Fiscal Note: Minimal

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RELEVANT AMA AND AMA-MSS POLICY

Environmental Protection 135.002MSS
AMA-MSS will ask the AMA to support strong federal enforcement and timely implementation of environmental protection regulations. (AMA Res 80, A-82 Referred) (BOT Rep D, I-82 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Modified: MSS CGPH Report A, I-18)

Environmental Contributors to Disease and Advocating for Environmental Justice 135.021MSS
AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows: Research into the Environmental Contributors to Disease and Advocating for Environmental Justice Our AMA will (1) advocate for the 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 and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. (MSS Res. 019, A-21)

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends. (4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. (BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19)

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed

manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. (CSA Rep. G, I-8; 9 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)

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees. (Res. 124, A-90) (Reaffirmed: Sunset Report, I-00) (Reaffirmed: CSAPH Rep. 1, A-10) (Reaffirmed: CSAPH Rep. 01, A-20)

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08) (Reaffirmation A-09) (Reaffirmed in lieu of Res. 402, A-10) (Reaffirmed in lieu of: Res. 504, A-16) (Modified: Res. 516, A-18) (Modified: Res. 923, I-19)

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants. (Sub. Res. 43, A-89) (Reaffirmed: Sunset Report, A-00) (Reaffirmation

I-06) (Reaffirmation I-07) (Reaffirmed in lieu of Res. 507, A-09) (Reaffirmed in lieu of Res. 509, A-09) (Reaffirmed: CSAPH Rep. 01, A-19)

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. (BOT Rep. R, A-82) (Reaffirmed: CLRPD Rep. A, I-92) (Amended: CSA Rep. 8, A-03) (Reaffirmation I-06) (Reaffirmed in lieu of Res. 509, A-09) (Reaffirmation I-09) (Reaffirmation A-14)

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.
2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA’s Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. (Res. 142, A-88) (Reaffirmed: Sunset Report, I-98) (Reaffirmation I-07) (Reaffirmed in lieu of Res. 507, A-09) (Reaffirmed in lieu of Res. 509, A-09) (Reaffirmation A-13) (Reaffirmation A-14) (Appended: Res. 917, I-18)

Preventing Death and Disability Due to Particulate Matter Produced by Automobiles H-135.915
Our AMA will: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) support individual states’ legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards. (Res. 915, I-19)

Environmental Health and Safety in Schools H-135.918
Our AMA: (1) supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner; (2) encourages the establishment of a system of governmental oversight, charged with ensuring the regular inspection of schools and identifying shortcomings that might, if left untreated, negatively impact the health of those learning and working in school buildings; (3) supports policies that increase

funding for such remediations to take place, especially in vulnerable, resource-limited neighborhoods; and (4) supports continued data collection and reporting on the negative health effects of substandard conditions in schools. (BOT Rep. 29, A-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 37
(A-23)

Introduced by: Sarah Mae Smith UC Irvine; Matty Dhillon, RJ Grewal, CHSU-COM; Alec Calac, UC San Diego School of Medicine; Adrina Kocharian, University of Minnesota Medical School; Justin Magrath, Tulane School of Medicine; Joey Ballard, Sydney Clark Indiana University School of Medicine; Andrew Nicholas, University of Cincinnati

Subject: Improving Medicaid and CHIP Access and Affordability

Sponsored by: Region 2, Region 3, Region 4, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Medicaid provides health care access to over 80 million people across the United States, including children, pregnant women, low-income adults, elderly adults, and people with disabilities, most of whom would otherwise be unable to afford or maintain adequate health insurance coverage[1]; and

Whereas, Children's Health Insurance Program (CHIP) offers additional coverage, specifically for children who don't qualify for Medicaid and lack other health insurance options[2]; and

Whereas, Federal standards limit out of pocket costs for Medicaid patients, including cost-sharing mechanisms preventing states from charging premiums to those under 150% of the Federal Poverty Level (FPL), forbidding co-payment charges for children, establishing maximum allowable co-payments based on income for adults, and limiting total family Medicaid expenditures to 5% of household income[3,4]; and

Whereas, States are freely able to establish cost-sharing measures, including co-payments, coinsurance, deductibles, and similar charges, to Medicaid enrollees above 150% of the FPL, imposing a financial barrier on patients[3,5]; and

Whereas, States can apply to Centers for Medicare and Medicaid Services (CMS) for Section 1115 waivers to implement changes that would be otherwise prohibited if they are "likely to assist in promoting the objectives of the Medicaid program" and budget neutral for the federal government[6]; and

Whereas, CMS has granted eight Section 1115 waivers allowing states to charge Medicaid premiums to patients below 150% of the FPL[4]; and

Whereas, Compared to Medicaid, there are fewer federal restrictions on premium and cost-sharing payments for CHIP, with 26 states currently requiring some sort of premium and 21 states utilizing cost-sharing[7]; and

Whereas, Medicaid and CHIP premiums are unaffordable for patients, as 80% of those disenrolled for non-payment in Montana reported this as their reason for non-payment, and failure to pay premiums can result in loss of coverage, disenrollments from enhanced benefits, and/or lockout periods[8]; and

Whereas, In Arkansas only 14% of enrollees made at least one eligible premium payment between January 2015 and April 2016, and in Michigan only 47% of those who owed premiums made at least one payment between October 2014 and January 2021[9,10]; and

Whereas, In Montana and Iowa 1,800 and 2,200 patients, respectively, lost Medicaid coverage in 2019 due to failure to pay premiums[4,11]; and

Whereas, In Indiana, from February 2015 through November 2016, failure to pay premiums led 13,600 individuals above 100% of the federal poverty line (FPL) to lose coverage, 46,200 individuals above 100% of the FPL to never be enrolled in coverage, and 289,000 individuals below the FPL to be moved from the comprehensive benefit package to the more limited benefit package[12]; and

Whereas, In Indiana and Wisconsin, failure to make premium payments results in being locked out of Medicaid coverage for a period of six months, while in Montana individuals are locked out until all missed premiums are paid[4]; and

Whereas, Medicaid and CHIP premiums are shown to increase disenrollment and discourage eligible adults and children from enrolling in these programs, resulting in these individuals being more likely to remain uninsured and having unmet medical needs[3]; and

Whereas, In Wisconsin, an increase up to $10 in monthly Medicaid premiums were shown to result in a 12% decrease in likelihood of remaining enrolled[13]; and

Whereas, Increasing per-child premiums reduces coverage, and this effect is maximal for those who fall further below the FPL[14]; and

Whereas, In Alabama, increases in premiums and copayments for the state's CHIP resulted in an 8% decrease in renewal, with African-American individuals, individuals with chronic conditions, and those with low family incomes being most likely to not renew[15]; and

Whereas, Coverage loss following premium hikes increases the share of uninsured patients seen by providers, resulting in a higher percentage of uncompensated care[16]; and

Whereas, The RAND Health Insurance Experiment found that increased cost-sharing reduced both necessary and unnecessary services at similar rates and led to worse health outcomes for the poorest and sickest patients[17]; and

Whereas, Recent studies have found that increases in Medicaid co-payments lead to reduced access to medications, increased rates of uncontrolled hypertension, and decreased rates of vaccination[18,19]; and

Whereas, State revenues from premiums and cost-sharing payments are limited and not necessary to provide coverage for patients[4]; and

Whereas, Michigan Medicaid premiums brought in an average of $3.4 million per year between 2014 and 2021, comprising less than 0.02% of Michigan's $20 billion annual Medicaid budget[10]; and

Whereas, The implementation of premiums and copayments can increase administrative burden and cost, with administrative costs associated with Arkansas's Section 1115 waiver nearly 30% higher compared to standard Medicaid[9]; and

Whereas, Medicaid premiums lead to an increased utilization of costlier medical care in the form of emergency rooms[20]; and

Whereas, The Families First Coronavirus Response Act has prevented states from disenrolling beneficiaries that would otherwhile lose coverage during the public health emergency (PHE)[21]; and

Whereas, Between 5.3 to 14.2 million people are projected to lose coverage at the conclusion of the PHE, which will be due, in part, to the reinstatement of Medicaid premiums[22]; and

Whereas, "Our AMA acknowledges that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right" (H-65.960); and

Whereas, Our AMA policy "advocate(s) strongly for expansion of the Medicaid program to all states" (D-290.979) and "opposes work requirements as a criterion for Medicaid eligibility" (H-290.961), therefore be it

RESOLVED, That our AMA oppose premiums, copayments, and other cost sharing methods for Medicaid and Children's Health Insurance Program (CHIP), including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries below 150% of the Federal Poverty Level; and be it further

RESOLVED, That our AMA amend H-290.982 by deletion as follows:
~~(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;~~; and be it further

RESOLVED, That our AMA encourage CMS to amend existing Section 1115 waivers disallowing states to charge premiums to Medicaid beneficiaries below 150% of the Federal Poverty Level.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Improving Affordability in the Health Insurance Exchanges H-165.824

1. Our AMA will: (a) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (b) support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level; (c) support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; and (d) encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.

2. Our AMA supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

Access to Care by Medicaid Patients H-290.989

Our AMA (1) requests CMS to improve Medicaid patients' access to care by considering physicians' costs in its determinations regarding the cost effectiveness of Medicaid third party liability requirement; and (2) will work with CMS and/or Congress to allow state Medicaid agencies to waive the requirement that physicians pursue third party payments prior to seeking payment from Medicaid.

Oppose Medicaid Eligibility Lockout H-290.960
Our AMA will oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods, and support provisions that permit them to reapply immediately for redetermination.

Medicaid Reform H-290.958
Our AMA supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Medical Care for Patients with Low Incomes H-165.855
(1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.
(2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
(3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.
(5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.
(6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.
(7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)
(8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 38
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Brooke Warren, UC San Francisco School of Medicine; Hailey Baker, University of Minnesota Medical School; Michelle Troup, University of South Carolina School of Medicine Greenville; Anna Klunk, Philadelphia College of Osteopathic Medicine

Subject: High Risk HPV Subtypes in American Indian and Alaska Native Populations

Sponsored by: Region 1, Region 2, Region 6, Student Osteopathic Medical Association, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Human Papillomavirus (HPV) is thought to be responsible for more than 90% of cervical cancers[1]; and

Whereas, American Indian/Alaska Native (AI/AN) people continue to disproportionately suffer the highest rates of HPV-associated cervical cancer, ranging from 9.5 to 21.1 per 100,000[1,2]; Whereas, AI/AN people are twice as likely to develop cervical cancer and four times as likely to die from cervical cancer than non-Hispanic Whites[2]; and

Whereas, Compared to other racial/ethnic groups, AI/AN women are less likely to be screened for HPV infection[3]; and

Whereas, AI/AN patients in recent studies were found to have higher rates of infection from high-risk HPV strains (34.8%) than the national average (20.7%), despite having higher HPV vaccination initiation rates[3]; and

Whereas, AI/AN patients were found to have higher prevalence rates of high-risk HPV strains not included in the 9-valent HPV vaccine, including strain HPV-51 in the Great Plains region[3]; and

Whereas, Sub-optimal screening for HPV infection among AI/AN women leads to decreased high-risk HPV typing and surveillance in this population[3,4]; and

Whereas, There currently exists insufficient data to account for significant variations in high-risk cervical cancer strains in AI/AN patients by geographic region (Northern Plains, Alaska, Southwest)[3,5-7]; and

Whereas, A study that evaluated the number of racial and ethnic minorities participating in U.S.-based clinical cancer trials found that only 0.048% of participants identified as AI/AN, despite comprising 2.9% of the U.S. population[8-9]; and

Whereas, Contributing factors to low research participation by members of minority populations has been cited as fear of discrimination by medical professionals, inability to access specialty care centers, a history of unethical medical testing, and insufficient time or financial resources[10];

Whereas, Historical wrongdoings against AI/AN people, such as the unethical distribution of research samples of the Havasupai tribal members and forced sterilization of AI/AN people throughout the nation, contributes to decreased participation by AI/AN people in research trials[11]; and

Whereas, AI/AN patients were insufficiently sampled for strains of high-risk HPV for vaccine development and vaccine impact studies, consistent with the overall underrepresentation of AI/AN individuals in vaccine clinical trials[3,6,12]; and

Whereas, Our AMA recognizes the importance of HPV vaccination in preventing cancer, supports availability of vaccination to all at-risk populations, encourages incorporation of vaccination into all health settings (H-440.872) and encourages health insurance coverage of vaccination (D-440.955); therefore it be

RESOLVED, That our AMA recognizes that there is a high-quality evidence gap for the screening, management, prevention, and treatment of American Indian and Alaska Native women with high-risk HPV infections; and be it further

RESOLVED, That our AMA will advocate to federal agencies to conduct epidemiological surveys of high-risk HPV subtypes most prevalent among American Indian and Alaska Native women.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-440.872 HPV Vaccine and Cervical Cancer Prevention Worldwide
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine 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.

D-440.955 Insurance Coverage for HPV Vaccine

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

H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

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

1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.
3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 39
(A-23)

Introduced by: Veenadhari Kollipara, Himi Begum, Eleni Fafoutis, Courtney Landis, Pennsylvania State University College of Medicine

Subject: Support for Research on the Efficacy of Workplace Suicide Prevention Interventions

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In the United States, rates of workplace suicide have been on the rise since 1992 till 2019, where a record number of 307 workplace suicide fatalities were reported[1]; and

Whereas, The populations most at risk for workplace suicides include the police, the army, the air force, farmers, and construction workers[2,3]; and

Whereas, Access to lethal means (i.e., firearms, agricultural equipment, construction machines, etc.) in the workplace present as occupation-specific suicide risk factors among the high-risk occupations stated above[4,5,6]; and

Whereas, Rates of deaths within occupations with access to lethal means are increasing, from 18.7 per 100,000 in 2011 to 24.8 per 100,000 in 2018 among active duty service members[7]; and

Whereas, For instance, one of the major causes of death of farmers in rural Wisconsin was the access to firearms and the burden of farming[8];

Whereas, Gender disparities are prominent, given that men have higher rates of workplace suicide compared to women in all occupational fields, except for computers and mathematics[3,9]; and

Whereas, Racial minority groups experience a disproportionately higher risk of work-related suicide compared to their white counterparts[4]; and

Whereas, Workplace suicides and the incidence of mental health disorders in the working population has increased all components of economic burden (i.e., direct costs, suicide-related costs, and workplace costs), with the incremental economic burden of adults with major depressive disorder at an estimated amount of US $330 billion in 2018[10]; and

Whereas, Suicide prevention interventions include a social support network system, collaboration of internal and external resources in the institution, and training of employers and employees[11]; and

Whereas, There is a lack of evidence-based/peer-reviewed literature that details suicide prevention trainings that are effective for the workplace[12,13]; and

Whereas, Existing AMA policy supports medical organizations and mental health organizations developing “a widely disseminated report on mental health treatment availability and suicide prevention” (Mental Health Crisis D-345.972); and

Whereas, Existing AMA policy supports “suicide prevention and mental health crisis services… to those populations at highest risk for” suicidal ideation and completion (Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974); therefore be it

RESOLVED, That our AMA support research on the efficacy of workplace suicide prevention programs in occupations with access to lethal means and higher rates of burnout to reduce workplace suicide in the USA.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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.

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.

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.

Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974
Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system, including the development of model legislation; and (3) collaborate with the Substance Abuse and Mental Health Services Administration, the 9-8-8 partner community, and other interested stakeholders, to strengthen suicide prevention and mental health crisis services that prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions, and self-injurious behavior.

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.

Increased Oversight of Suicide Prevention Training for Correctional Facility Staff H-430.984
1. Our AMA strongly encourages all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation.
2. Our AMA strongly encourages all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

American Indian / Alaska Native Adolescent Suicide D-350.988
Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide.

Preventing Resident Physician Suicide 310.054MSS
AMA-MSS (1) urges residency programs to include of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities.

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.

Reducing Suicide Risk among LGBTQ+ Youth through Collaboration with Allied Organizations 65.015MSS

AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce LGBTQ+ youth suicide and improve health among LGBTQ+ youth.

Suicide Prevention Program for Medical Students 295.058MSS
AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 40
(A-23)

Introduced by: Lauren Sternberg, John A. Burns School of Medicine at the University of Hawai'i at Mānoa; Zainub Dhanani, Stanford University School of Medicine; Madison Hoenle, University of Illinois College of Medicine Rockford; Travis Jackson, University of Missouri School of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Syeda Akila Ally, University of Illinois College of Medicine Chicago; Minali Nemani, Edward Via College of Osteopathic Medicine- Louisiana Campus; Peter Park, Amanda Block, Anne Burnett Marion School of Medicine; Caitlin Aguirre, UTMB John Sealy School of Medicine; Maya Ramy, Texas A&M School of Medicine; Kimberly Ibarra, Sam Houston State College of Osteopathic Medicine; Nora Newcomb, Alexis Behne Sharma, Zeegan George, University of South Florida Morsani College of Medicine; Courtney Lubaczewski, Olivia Larner, University of South Carolina School of Medicine Greenville; Samantha Pavlock, Florida State University College of Medicine;Swara Sarvepalli, Erin DuRoss, Central Michigan University College of Medicine; Gloria McGurn, Michigan State University College of Human Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine; Krishna Channa, Dean Kim, and Kaitlyn Petitpas, UConn School of Medicine; Michelle Klausner, New York Medical College; Jocelyn Wensel, International University of Health Sciences

Subject: Provision of Continuation of Health Insurance Benefits for Medical Students Taking a Leave of Absence

Sponsored by: Region 1, Region 2, Region 5, Region 7, Association of Native American Medical Students, PsychSIGN, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The Association of American Medical Colleges defines a leave of absence (LOA) as a period of non-enrollment during which a student is usually not required to pay (full) tuition and fees[1]; and

Whereas, Common reasons for medical student LOA include parental leave, personal medical leave, caring for a family member, research or educational opportunities, and academic underperformance[1]; and

Whereas, According to a national survey of 3,162 medical students from 110 allopathic medical schools, 17.5% considered taking an LOA, while 3.8% of students ultimately took a LOA during their undergraduate medical education, [2,3]; and

Whereas, Medical students from African American, Asian, Native Hawaiian and Pacific Islander, American Indian and Alaska Native, and Hispanic/Chicano/Latino households were more likely to take LOAs compared to those from other racial and ethnic backgrounds[4]; and

Whereas, Students who are from lower income households are more likely to take a LOA compared to students from higher income households[4]; and

Whereas, Black adults have a higher chronic disease burden than non-Black adults, further accompanied by higher ambulatory care and Emergency Department utilization rates[5,6]; and

Whereas, Black medical students may disproportionately face higher healthcare burden/costs to manage on top of medical school[5-9]; and

Whereas, Lower income/ low socioeconomic status (SES) background is associated with higher health service utilization[5,6]; and

Whereas, Students who identify as disabled are more likely to take a leave of absence compared to their peers[10]; and

Whereas, Young adults with physical disabilities are at higher risk of having unmet health care needs and using last-resort health care services compared to their peers, thus medical students with physical disabilities may have greater healthcare utilization and needs[11]; and

Whereas, Often these students are without comprehensive and easily navigable insurance coverage through their medical school while on leave[12]; and

Whereas, Taking a LOA may result in loss of access to health insurance, mental health centers, campus housing, and student loan funds, and is in conflict with AAMC Group on Student Affairs Recommendations for Student Healthcare and Insurance[12]; and

Whereas, Changes in insurance status during LOA provoke feelings of stress among medical students[12]; and

Whereas, Many medical schools that offer health insurance to students taking LOAs have multiple restrictions or convoluted processes to obtain medical benefits, such as New York Medical College School of Medicine, students granted an LOA are eligible to purchase student health insurance from the College but are not covered by the college disability insurance policy during their leaves[13]; and

Whereas, At Brown University, students who take a Medical Leave of Absence who have been previously insured under the Student Health Insurance Plan (SHIP) for the enrollment period immediately prior to taking the leave of absence are eligible to enroll in SHIP for a maximum of one year and the Graduate School or the Division of Biology and Medicine will pay their insurance premium. It is not possible to extend enrollment in SHIP beyond one year even if the leave is extended further[14] ; and

Whereas, At Harvard University, health insurance coverage during LOA is much more complicated, with 3 separate potential timelines for insurance transition from full time student coverage to LOA/withdrawal coverage and restriction to continue the same breadth/scope of coverage regardless of changes in medical need potentially being the reason for LOA[15-17]; and

Whereas, AMA policy H-405.960 “Policies for Parental, Family and Medical Necessity Leave” addresses provision for continuation of insurance benefits for physicians and residents taking leave, but not for medical students[18]; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to support continuation of comprehensive medical insurance benefits for students taking a leave of absence; and be it further

RESOLVED, That our AMA-MSS advocate for medical schools to develop written policies regarding whether provisions are made for continuation of insurance benefits during leave.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges 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 the 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 collect data on childbirth and parenthood from all accredited US residency programs annually and publish this data with disaggregation by gender identity and specialty.
18. These policies, as above, should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency, or fellowship.
CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22

Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856
Our AMA: (1) supports the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved; and (2) encourages the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved. Res. 322, A-19

Insurance Coverage for Medical Students and Resident Physicians H-295.942
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the

ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.
Res 412, A-06; Appended: Res 907, I-12

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS
AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

Adequate Insurance for Medical Students and Residents 295.027MSS
AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such

policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. AMA Res 252, A-9; Referred BOT Rep W, I-91; Adopted [H295.942]; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Reaffirmed: MSS GC Rep B, A-21

Insurance Education for Medical Students 295.172MSS
AMA-MSS will ask the AMA to work with the AAMC, AACOM, LCME, and COCA to encourage integration of medical educational curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician's role in obtaining affordable care for patients. MSS Res 5, I-12; Reaffirmed: MSS GC Report A, I-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 41
(A-23)

Introduced by: Brooke Buckingham, University of Toledo College of Medicine; Julia Silverman, Elizabeth Suschana, University of Connecticut School of Medicine; Ida Vaziri, UT Health San Antonio Long School of Medicine; Sydney Clark, Indiana University School of Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine; Whitney Stuard, UTSW; Elisabeth McCallum, University of California, Irvine School of Medicine; Syeda Akila Ally, University of Illinois College of Medicine; Sneha Krish, Virginia Commonwealth University/MCV School of Medicine; Sara Kazyak, Wayne State University School of Medicine; Melinique Walls, University of Chicago Pritzker School of Medicine

Subject: Opposition to Restrictions on United States Foreign Aid Allocation for Reproductive Healthcare

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In 2020, the World Health Organization listed access to comprehensive abortion care to be a human right and an essential health care service[1]; and

Whereas, The United Nations' (UN) Humans Rights Committee (HRC) and American Public Health Association (APHA) have expressed that abortion is necessary to ensuring the right to life for women and girls due to its role in prevention of maternal morbidity and mortality[2,3]; and

Whereas, Abortion is one of the most common medical procedures globally, as data from 1990 to 2019 has shown that approximately 61% of unintended pregnancies end in abortion, with an average of 73.3 million abortions annually and estimated 39 abortions per 1000 women aged 15 to 49 years old[4]; and

Whereas, People in low- and middle-income countries (LMICs) face particular difficulty in accessing abortion care, including long travel distances, confusing healthcare system navigation, limited clinic access, and financial constraints[5]; and

Whereas, Delayed access to abortion care or inability to access abortion care increases risk of birth complications and death, increased cost of care, mental health consequences, and increased risk of remaining in poverty and suffering from interpersonal violence[6]; and

Whereas, Difficulty accessing abortion care commonly leads to unsafe abortions, including ingestion of toxic fluids such as bleach, inflicting direct injury to the vagina, placing dangerous medications into the vagina or rectum, or inflicting blunt trauma to the abdomen[7]; and

Whereas, Over 13.2% of maternal deaths worldwide can be attributed to unsafe abortion, necessitating approximately 7 million women per year in low- and middle-income countries

(LMICs) to seek hospital treatment for complications such as incomplete abortion, hemorrhage, infection, and perforation[8]; and

Whereas, The percent of maternal deaths due to unsafe abortions is significantly higher in LMICs than in more developed nations (30 versus 220 deaths per 100,000)[9]; and

Whereas, The United States is the largest contributor to global family planning and reproductive health, supporting these efforts for over 50 years and contributing $600 million in 2022 alone[10]; and

Whereas, The U.S. Agency for International Development (USAID) operates family planning and reproductive health programs in more than 30 countries, with priority efforts focused in Africa and parts of Southern Asia, particularly in LMICs with extremely vulnerable populations[11,12]; and

Whereas, The Helms Amendment, a part of the Foreign Assistance Act of 1973, prohibits the use of federal funds from the United States for abortion care in international countries, including in cases of rape, incest, and danger to the life of the pregnant person[13]; and

Whereas, The Mexico City Policy (MCP) "prohibits United States (US) funding to foreign non-governmental organizations (NGOs) that advocate for or provide access to abortion information, referrals or services, even with their own, non-US dollars" and has been rescinded and reinstated by various presidential administrations since its introduction in 1984[14]; and

Whereas, While the MCP previously only affected organizations that provided family planning, in 2017, President Trump implemented Protecting Life in Global Health Assistance, an expansion of the MCP which has become known as the "global gag rule", that now affects organizations providing care for HIV and AIDs, maternal and child health, malaria, tuberculosis, nutrition, non-communicable diseases, water sanitation and hygiene, and zika virus[14,15]; and

Whereas, This expansion of policy by the Trump administration exemplifies the detrimental policy amendments that can occur with each change of administration[14,15]; and

Whereas, In circumstances where programs cannot agree to the global gag rule's terms, and that relied heavily on US partnership, they will be left without significant local capacity to implement their services, as many countries lack alternative organizations that can absorb funding and implement effective programs[16]; and

Whereas, Data has shown that the periods of time in which the Mexico City Policy was in effect, sub-Saharan African countries experienced an increase in prevalence of abortion by approximately 4-8 abortions per 10,000 women-years and a reduction in contraception use by 13.5%[17]; and

Whereas, Of the 56 countries receiving U.S. financial health assistance, 86% legally allow abortion in at least one circumstance, but are unable to offer this care to patients due to the restrictions imposed by the Helms Amendment[14]; and

Whereas, There are numerous examples of individual women who have been directly impacted by these policies, including circumstances in which NGO's have run out of manual vacuum aspiration instruments in an attempt to avoid supporting abortion services, resulting in the

inability to treat pregnancy complications including postpartum hemorrhage and unsafe abortions[18]; and

Whereas, Under AMA policies D-5.999, "Preserving Access to Reproductive Health Services," and H-5.993, "Right to Privacy in Termination of Pregnancy," the AMA supports the position that access to reproductive health care is a human right and the termination of pregnancy is a medical matter between the patient and the physician, opposing any limitations to the access of these services; and

Whereas, According to existing policy "International Strategy" (G-630.070), our AMA "recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship" and "supports the activities of the World Medical Association (WMA) to improve health care in developing countries"; therefore it be

RESOLVED, That our AMA oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care; and it be further

RESOLVED, That our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Expanding Support for Access to Abortion Care D-5.996
1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.

Right to Privacy in Termination of Pregnancy H-5.993
The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

Freedom of Communication Between Physicians and Patients H-5.989
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Protecting the Patient-Physician Relationship H-165.837
Our AMA: (1) supports protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based

decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements; and (2) will continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling.

Government Interference in Patient Counseling H-373.995
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959
1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

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.

The Criminalization of Health Care Decision Making H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

International Strategy G-630.070
1. Our AMA recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship.
2. The AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations.
3. The AMA: (a) continues to support the World Health Organization as an institution; (b) advocates full funding as understood by the United States Government for the World Health Organization; (c) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (d) encourages the World

Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.
4. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO.
5. The AMA will include the International Medical Graduates Section as a resource for international medical initiatives.
6. The AMA will: (a) continue to focus its international activities on and through organizations that are multinational in scope; (b) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (c) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (d) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (e) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (f) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives.
7. Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

Public Funding of Abortion Services 5.001MSS
AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)

Patient Confidentiality and Reproductive Health 5.003MSS
AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion. (MSS Amended Res 11, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

MSS Stance on Challenges to Women’s Rights to Reproductive Health Care Access 5.005MSS
AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A16) (Reaffirmed: MSS Res 059, A-

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 42
(A-23)

Introduced by: Joshua Rayham, Wayne State University School of Medicine

Subject: Advocacy for Researching the Benefits and Cost-efficacy of Patient Navigation Programs Outside the Realm of Oncology

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Patient navigators are trained professionals who guide patients through the healthcare system, help them access appropriate care, and coordinate care across different providers and settings[1]; and

Whereas, Patient navigation addresses structural, cultural, social, emotional, and administrative barriers, including: finances, language, transportation, and work-related issues, which reduce initial visits, care plan adherence, and patient follow-up, particularly in underserved patient populations across the care continuum[2-5,13]; and

Whereas, Patient navigators have knowledge of cancer screening, diagnosis, treatment, survivorship, and related physical, psychological, and social issues, and can document any care barriers, resources, or referrals for resolution in the client or medical record[13]; and

Whereas, Currently available research considers the responsibilities of patient navigators as roles that could be taken up by other healthcare professionals including physicians, care managers, nurse managers, physical therapists, or pharmacists[8,16-22]; and

Whereas, Patient navigators can be individuals that are trained specifically in patient navigation and can be integrated as members of interdisciplinary teams or made up from existing members of those teams, such as physicians, social workers, nurses, care managers, etc.[7,8]; and

Whereas, Social workers are specifically educated professionals that play a pivotal role in healthcare settings by providing support, advocacy, and assistance to patients and families facing social, emotional, and practical challenges related to their health conditions.[5,6].; and

Whereas, Social workers address clinical and service delivery barriers to care, which include the provision of services to at-risk populations defined by individual need, high-acuity or high-volume at an institutional level, they do not specifically perform patient navigation functions such as identifying and addressing patient needs and barriers, providing information, and addressing

patient follow-up[1,5,6,13]; and

Whereas, A cardiology patient navigation program was established amongst 35 hospitals nationally as a pilot program consisting of navigation teams of clinically trained individuals, including various combinations of nurses, pharmacists, care managers, physicians, nutritionists and physical therapists[8]; and

Whereas, Patient navigation has been shown to improve outcomes, reduce stigma, reduce the financial burden for cancer patients, and improve overall quality of care for patients experiencing the following: cancer; managing chronic health conditions such as HIV/AIDs or diabetes; cardiovascular diseases; patients struggling with mental health issues and addiction and maternal care[8-11,15-18]; and

Whereas, Patient navigation has been well established for cancer care by providing patients with knowledge about screening, increasing follow-through on obtaining screenings and follow-up care after receiving results[9,15]; and

Whereas, A relatively small randomized control study done by a specific program amongst those who established a patient navigation program for cardiology has shown that navigation teams were able to significantly improve patient health literacy of heart failure, as well as 14-day follow up attendance, and showed a strong correlation with intervention and reduced heart failure related readmission rates[8]; and

Whereas, For patients with HIV/AIDs, patient navigators assisted patients by establishing themselves in mentorship roles and helping to facilitate clients' engagement with social services and care systems[10,18,21]; and

Whereas, Limited research in patient navigation for managing diabetes was associated with improved glycemic control and better clinic engagement among patients with diabetes[11,19-21]; and

Whereas, Patient navigation for mental health and addiction (MHA) treatment was found to significantly improve outcomes for individuals experiencing MHA issues, including reductions in symptoms, fewer barriers to care, and increased quality of life as compared to controls, although long-term effects of patient navigation in this field still need to be studied[21,22].

Whereas, There has been an effort to expand patient navigation into other specialties, such as trauma care, nephrology, and transplants, with mixed results[8,21,23-25]; and

Whereas, With regards to cancer care, patient navigation programs have been shown to be financially beneficial for hospitals that have implemented such programs by reducing total spending per patient, as reflected by increased screenings and reducing no-show rates by 3%[9,14]; and

Whereas, The use and completion of cancer screening services increased after patient navigation programs were implemented[9,12,15,21]; and

Whereas, For Medicare patients with breast cancer, there was an average savings of $528 per patient per quarter, and each navigator could navigate 100-150 patients per quarter; this cost savings more than offset their salary, $41,369 ($35,000 – $47,000) [12,27]; and

Whereas, A six-month Accenture-MetroHealth study showed that two patient navigators were able to add $150,000 in additional hospital revenue per year[14].

Whereas, Patient navigation in cancer care settings has high overhead costs upfront for hiring and training, yet, the workflow and increased service use offset the cost and generate net profits for hospital systems[9,14].

Whereas, There are limited well researched studies looking into the cost and benefits of patient navigation for specialties outside of cancer care[9].

Whereas, There are free tools available for hospitals to use so that they can establish oncology patient navigation, such as The Patient Navigation Barriers and Outcomes Tool (PN-BOT™)[26]; and

Whereas, Current AMA policy H-373.994 sets guidelines for the primary role of patient navigators as facilitators of patient empowerment and information providers so that patients are able to make well-informed decisions; therefore be it

RESOLVED, That our AMA supports research into the benefits of patient navigation in other clinical specialties outside of oncology; and be it further

RESOLVED, That our AMA supports research into the cost-efficacy of patient navigation programs in other fields outside of oncology to better understand if patient navigation is cost-effective for hospitals to implement.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Patient Navigation Programs H-373.994
“Our AMA recognizes the increasing use of **patient** navigator and **patient** advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that **patient** navigator services enhance the delivery of high-quality **patient** care, our AMA supports the following guidelines for **patient** navigator programs.”

Incorporating Community Workers into the US Healthcare system

https://policysearch.ama-assn.org/councilreports/downloadreport?uri=/councilreports/i15_cms_report7.pdf
" submitted by the AMA Medical Student Section. Resolution 805-I-14 asked "that the 4 AMA: 1) encourage the incorporation of community health workers into the US health care system 5 and support legislation that integrates community health workers into care delivery models 6 especially in communities of economically disadvantaged, rural, and minority populations; and 2) 7 support appropriate stakeholders to define community health workers in order to define their 8 required level of training and scope of practice and to legitimize their role as health care 9 providers."

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 43
(A-23)

Introduced by: John Slunecka, University of South Dakota Sanford School of Medicine; Shaminy Manoranjithan, University of Missouri School of Medicine; Gino Dettorre, Victoria Mityul, Washington University School of Medicine in St. Louis; Ananya Sharma, Vanderbilt University School of Medicine; Samantha Pavlock, Joseph Brandon Parker, Florida State University College of Medicine; Kaye Dandrea, University of New England College of Osteopathic Medicine; Wyatt Lanik, University of Nebraska College of Medicine; Udit Vyas, Indiana University School of Medicine; Matthew Linz, Rutgers New Jersey Medical School; Chandana Kulkarni, Burnett School of Medicine at Texas Christian University; Jahnavi Sunkara, Caitlin Reichard, Onajia Stubblefield, University of Louisville School of Medicine

Subject: Support for Increased Diversity in Genetic Research

Sponsored by: Region 5, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Genetic research studies have historically included poorly diversified cohorts with 78% of genome-wide association study (GWAS) participants identifying as non-Hispanic White, 10% identifying as Asian, 2% identifying as African American, 1% identifying as Hispanic or Latino, and <1% identifying as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander,1-3; and

Whereas, GWAS do not reflect the United States' population demographics, as the U.S. population is 59.3% non-Hispanic White, 18.9% Hispanic or Latino, 13.6% African American, 6.1% Asian, 1.3% American Indian and Alaska Native, and 0.3% Native Hawaiian and Other Pacific Islander 4; and

Whereas, Race and ethnicity are "socially ascribed identities," while genetic ancestry is defined as the genetic origin of a given population and via greater genetic similarity within a given population5,6,13,14; and

Whereas, Many genetic markers associated with a given trait or disease are used for the determination of genetic risk for said trait or disease through a method called polygenic risk scores (PRS) through the use of GWAS data7; and

Whereas, The ability of PRS to accurately assess genetic risk for disease within the general population depends on the diversity of the subjects used for generating the PRS2; and

Whereas, PRS generated using genetic data from one specific genetic ancestry population have been shown to be less accurate for a different genetic ancestry population8,9; and

Whereas, PRS has the potential to be used as a screening tool for a variety of diseases including cancer, diabetes, cardiovascular disease, and mental health disorders as part of preventive care10; and

Whereas, PRSs have been shown to identify 10-20 times as many individuals at risk of coronary artery disease compared to monogenic variants which may better capture patients who may benefit from lipid-lowering therapy11; and

Whereas, Failure to account for genetic differences in pharmaceutical studies can lead to adverse health outcomes; As an example, in 2008 in Sub-Saharan Africa failure to account for G6PD-mutations led to withdrawal of antimalarial chlorproguanil-dapsone2; and

Whereas, Lack of a diversified population in genomic studies of hypertrophic cardiomyopathy misclassified a variant in African-Americans as pathogenic due to the allele's rarity in the majority White populations studied15,16; and

Whereas, Systematic review has demonstrated that certain ethnicities and races did not participate in genetics studies due to decreased understanding of genetics and a lack of knowledge about genomic studies, though were willing to participate when this barrier was addressed16; and

Whereas, The exclusion of certain allelic variants in research poses a large public health burden, and may lead to increased adverse outcomes and therefore potential for increased costs16,18; and

Whereas, The NIH National Human Research Genome Institute requires funded clinical sites to enroll a minimum of 60% participants of non-European ancestry, medically underserved populations, or populations who experience poorer health outcomes17; and

Whereas, The NIH National Human Research Genome Institute uses many pragmatic clinical trial designs to build its structural evidence base, which exclude patients who lack insurance or Medicaid coverage17; and

Whereas, The NIH All of Us Research Program aims to accelerate health research through addressing the need for diversity, though still lacks inclusion of certain demographics in their study, including gender identity and education status19; and

Whereas, Disadvantaged populations face unique barriers in participating in research studies, including language discordance, lack of trust in the healthcare establishment, financial burden, low literacy, lack of transportation, and lack of information20; and

Whereas, AMA policy H-65.952 “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 and states “our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies”; and

Whereas AMA policy D-350.981 recognizes the dangers of racial essentialism in medicine, states they “will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors” and “support research that promotes antiracist strategies to mitigate algorithmic bias in medicine”; and

Whereas, AMA policy H-65.953 “recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology”, “supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice”, “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.“, and “recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease”, but does not acknowledge the importance of diversity in genetic research; and

Whereas, AMA policy H-460.911 supports increasing minority, female, and other underrepresented group participation in clinical trials; and

Whereas, AMA policy H-480.944 supports research and open discourse in medical genetics; therefore be it

RESOLVED, That our AMA support the diversification of genetic research to include subjects from multiple genetic ancestries; and be it further

RESOLVED, That our AMA support the recruitment of individuals from underrepresented genetic ancestry groups for participation in genetic research studies, especially those regarding genetic risk; and be it further

RESOLVED, That our AMA encourage the NIH to increase funding for outreach and recruitment of members of underrepresented genetic ancestry groups and the sharing of such deidentified genetic data with the scientific community; and be it further

RESOLVED, That our AMA promotes public education regarding PRSs and genetic research participation in order to aid in the recruitment of diverse ancestry cohorts for future genetic studies; and be it further

RESOLVED, That the AMA amend Policy H-460.909, “Comparative Effectiveness Research,” by addition and deletion to read as follows:

Comparative Effectiveness Research H-460.909

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

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

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

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

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

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

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

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

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

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

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

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

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-65.952 Racism as a Public Health Threat
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.
Res. 5, I-20Reaffirmed: Res. 013, A-22Modified: Speakers Rep., A-22

D-350.981 Racial Essentialism in Medicine
1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may

perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Res. 10, I-20

H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.
Res. 11, I-20

H-460.911 Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research
1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials; c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of

underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility.
3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
BOT Rep. 4, A-08Reaffirmed: CSAPH Rep. 01, A-18Modified: Res. 016, I-22

H-480.944 Improving Genetic Testing and Counseling Services
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. (Res. 913, I-16)

D-460.976 Genomic and Molecular-based Personalized Health Care
Our AMA will:
(1) continue to recognize the need for possible adaptation of the US health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans;
(2) support studies aimed at determining the viability of prospective care models and measures that will assist in creating a stronger focus on prospective care in the US health care system;
(3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing;
(4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and
(5) promote the appropriate use of pharmacogenomics in drug development and clinical trials.
(CSAPH Reaffirmed Rep 01, A-20)

440.116MSS Recognizing the Burden of Rare Disease
AMA-MSS will ask the AMA to: (1) recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases; and (2) support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases. (MSS Amended Res 027, A-22 adopted, MSS RES 190 HOD pending)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 44
(A-23)

Introduced by: Jesse Garcia, University of San Diego School of Medicine;
Joey Ballard, Indiana University School of Medicine

Subject: Improving Medigap Protections

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Traditional Medicare is widely accepted and portable, helping to provide reliable coverage to those who qualify[1]; and

Whereas, Considering that Traditional Medicare only includes Part A hospitalization and Part B doctor and outpatient care, and maintains a outpatient coinsurance, hospital deductible, and no out-of-pocket maximum, beneficiaries often obtain supplemental plans such as Medicare Advantage or Medigap to help pay certain costs[2, 3]; and

Whereas, Medicare Advantage plans, a form of private insurance that often includes hospital, doctor and outpatient services, and prescription drug coverage, are limited by geographically biased provider networks, enrollment periods, and the prohibition to enroll in additional Medigap policy to cover additional out-of-pocket expenses[3-5]; and

Whereas, Medicare Advantage Organizations sometimes delay or deny Medicare Advantage beneficiaries' access to services, even though the requests meet Medicare coverage rules, and have higher disenrollment rates amongst racial/ethnic minority beneficiaries[6-8]; and

Whereas, Medigap is tightly regulated by the Centers for Medicare and Medicaid Services (CMS) and is the one of the most popular supplemental insurance plans for Traditional Medicare beneficiaries with over 14 million enrollees[9,10]; and

Whereas, Those 65 or older with Medicare Part B are eligible to buy Medigap policy, preferably, during the six month enrollment period; thereafter, there is no guarantee that an insurance company will enroll beneficiaries unless they meet medical underwriting requirements[10]; and

Whereas, Beneficiaries subscribed to Medigap policy have certain protections during the six month enrollment period, including Guaranteed Issue and Community Rating[11]; and

Whereas, Guarantee Issue requires insurers to sell a policy and not drop individuals based on insurability, and rating systems prevent insurance companies from charging higher premiums based on health information[12]; and

Whereas, Community Rating provides strong consumer protection because premiums can not be adjusted due to an applicant's or policyholder's age or health status[10-12]; and

Whereas, As of 2018, only eight states required carriers to use lifetime Community Rating and just four states require Medigap policies to be issued, but of these, only two states maintain Guaranteed Issue year-round protections[11,13]; therefore be it

RESOLVED, That our AMA advocates for annual Medigap open enrollment periods and guaranteed lifetime enrollment eligibility for those enrolled in Medicare; and be it further

RESOLVED, That our AMA advocates that Medigap insurers offer lifetime Community Rated policies to protect against premium adjustments for age and health-related changes amongst Medicare enrollees.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by **guaranteed** renewability.
(6) **Guaranteed** renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) **Guaranteed issue** regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with **guaranteed issue** within the context of an individual mandate, in addition to **guaranteed** renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 45
(A-23)

Introduced by: Inchara Raj, University of Texas Medical Branch/John Sealy School of Medicine; Alex Grayson, University of Cincinnati College of Medicine; Eve Emmanouilidou, Carle Illinois College of Medicine; Darya Mirebrahimi, Thérèse Weidenkopf, Samantha Matthesen, Virginia Commonwealth University School of Medicine

Subject: Addressing Transparency of Funds of Crisis Pregnancy Centers

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Unintended pregnancy is disproportionately seen among adolescents, those of lower income, minorities, and single women, thus furthering their economic burden and widening economic disparities[1,2]; and

Whereas, Women with unintended pregnancies, adverse social circumstances, and a lack of support will experience higher rates of migraines, anxiety, cardiovascular disease, depression, and cancer[3]; and

Whereas, Most women are not familiar with their legal right to reproductive care and abortion in their state, as seen by a survey of 1,057 women, where only 18% of questions were answered correctly regarding these rights in their state[4]; and

Whereas, Crisis Pregnancy Centers are defined as non-profit, non-medical facilities that attempt to embody legitimate reproductive health clinics while offering services to discourage their clientele from seeking abortions[5]; and

Whereas, Crisis Pregnancy Centers are often located near abortion clinics in hopes of promoting confusion amongst clients about where to go for an abortion[6]; and

Whereas, Clientele of Crisis Pregnancy Centers are disproportionately individuals of low income who often attribute seeking out the centers due to the free services provided[7,8]; and

Whereas, 63% of Crisis Pregnancy Centers promote false and/or biased medical claims, including false statements attempting to link abortion to poor mental health outcomes, future infertility, and breast cancer[9,10]; and

Whereas, Only 25% of Crisis Pregnancy Centers have a registered nurse on staff and only 16% have a physician on staff, with some of these licensed professionals lacking credentials in reproductive health[10]; and

Whereas, As non-licensed medical clinics, Crisis Pregnancy Centers are not bound by the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA)[6]; and

Whereas, 7 states use federal Temporary Assistance for Needy Families (TANF) finances, which are meant to provide a safety net for low-income families, to fund Crisis Pregnancy Centers[11]; and

Whereas, Title X Grants frequently fund Crisis Pregnancy Centers as family planning clinics, despite their failure to include services related to preventing pregnancy[2,11]; and

Whereas, 18 states utilize “choose life” license plate sales to fund Crisis Pregnancy Centers[5]; therefore be it

RESOLVED, That our AMA advocates that Crisis Pregnancy Centers clearly and transparently disclose their current sources of private, state, and federal funding, as well as any changes to said funding; and be it further

RESOLVED, That our AMA advocates that Crisis Pregnancy Centers that do not adhere to policy H-420.954 and the currently proposed funding disclosure should lose eligibility for state and federal funding; and be it further

RESOLVED, That our AMA advocates supporting funding for legitimate reproductive health clinics and not Crisis Pregnancy Centers.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. It is AMA's position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals. (2) Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling. (3) Our AMA advocates that any entity offering crisis pregnancy services (3a) truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient; and (3b) be transparent with respect to their funding and sponsorship relationships. (4) Our AMA advocates that any entity licensed to provide medical or health services to pregnant women (4a) ensure that care is provided by appropriately qualified, licensed personnel; and (4b) abide by federal health information privacy laws. (5) Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate health information to support patients' informed, voluntary decisions. Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21; Modified: BOT Rep. 14, A-22

Expanding Support for Access to Abortion Care D-5.996

1. Our AMA will advocate for: (A) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (B) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (C) equitable participation by physicians who provide abortion care in insurance plans and public programs.

2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care. Res. 229, I-22

Policy on Abortion H-5.990

The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures. Res. 158, A-90; Reaffirmed: Sub. Res. 208, I-96; Reaffirmed: BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19; Modified: BOT Rep. 4, I-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 46
(A-23)

Introduced by: Senila Yasmin, MPH, Abdurrahman Abdurrob, Jacob Rha, Tufts University School of Medicine; Nada Dakka, Khristian Burke, Central Michigan University College of Medicine; Aila Rahman, Wayne State University; Priya Desai, Boston University Chobanian & Avedisian School of Medicine; Sara Youssef, University of Arizona College of Medicine-Tucson

Subject: Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Spirituality is important to many patients with serious illness;[1] and

Whereas, Frequent religious service attendance was associated with lower risk of all-cause mortality, suicide, and depression;[2] and

Whereas, Early research indicates broad agreement that religion is a social determinant of health and involvement in religion is linked to mostly beneficial health outcomes;[3] and

Whereas, Many faiths, including but not limited to Christianity, Judaism, Islam, Buddhism, and Baha'i preach daily prayer, reflection, or meditation as spiritual practices;[4] and

Whereas, The most likely religious group to experience discrimination in institutional settings were Muslims, according to The Institute for Social Policy and Understanding's (ISPU) American Muslim Poll 2022: A Politics and Pandemic Status Report;[5] and

Whereas, Numerous studies have highlighted how the lack of cultural competence and healthcare accommodations, such as prayer spaces, are reasons Muslim patients delay healthcare, and Muslim patients have expressed that it is difficult for them to complete their obligatory daily prayers when admitted to in-patient medical institutions and while accessing medical care;[6–8] and

Whereas, Many physicians note that their religion and faith has contributed positively to providing exceptional patient care;[9] and

Whereas, A 2021 study found an association between better spiritual well-being of residents with greater sense of work accomplishment, overall self-rated health, decreased burnout and depressive symptoms;[10] and

Whereas, A 2021 study found that identification as an active participant within a religious affiliation had statistically significant lower burnout scores among medical students ;[11] and

Whereas, Muslims must perform ablution, or *wudhu*, before prayer and pray 5 times a day in a quiet, clean space;[6,7] and

Whereas, Oriental Orthodox Christians must pray the canonical hours seven times a day, and Jewish law requires Jews to pray three times a day;[12,13] and

Whereas, The provision of spiritual care in the medical care of patients with serious illness is associated with better end-of-life outcomes;[1] and

Whereas, Results from a survey following implementation of reflection spaces in the hospital showed that 90% of responders displayed a preference for using the reflection room versus a hospital unit;[14] and

Whereas, Interfaith prayer and reflection rooms are a viable solution to providing diverse student populations a space for spirituality, while also creating an opportunity for awareness of religious pluralism on university campuses;[15] and

Whereas, Medical students would feel more supported if their religious and cultural beliefs are valued;[16] and

Whereas, Recently, some medical institutions and schools are recognizing the importance and need for interfaith prayer spaces and have started to create those spaces for their students and personnel;[16-19] and

Whereas, Liaison Committee on Medical Education (LCME) standard IS-16 and element 3.3 state that medical education programs must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds;[20] and

Whereas, In 2011, the Association of American Medical Colleges (AAMC) “encouraged medical institutions to embrace a framework for diversity that included removing social…barriers to diversity,” but stated almost a decade later that this has not happened;[21] and

Whereas, The AAMC’s Chief Diversity and Inclusion Officer, David A. Acosta, MD, has stated that true equity is reached when “*every* person in the academic medical community” can obtain their full potential regardless of their social identity;[22] and

Whereas the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity has provided a blueprint for the AMA to amplify and integrate often "invisible-ized" narratives of historically marginalized physicians and patients;[23]

Whereas, The AMA states it is committed to maintaining diversity, equity, and inclusion among medical students and physicians;[24] and

Whereas, According to Policy 65.021MSS, AMA-MSS supports expanded patient spirituality access in medicine, and further supports spirituality services for healthcare workers;[25] and

Whereas, Policy H-160.900 states that the AMA recognizes the impact spirituality has on health and encourages patient access to spirituality;[26] and

Whereas, Policy D-200.985 states that the AMA will encourage the LCME to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty;[27] and

Whereas, Policy H-295.927 encourages the AMA, LCME, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students;[28] and

Whereas, Policy D-350.996 states that as part of their advocacy and public health efforts, the AMA will incorporate strategies that eliminate minority health care disparities;[29] therefore be it

RESOLVED, That the AMA advocate for the creation and upkeep of dedicated interfaith prayer spaces and spaces for ritual purification in medical schools and healthcare facilities.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

65.021MSS Addressing Patient Spirituality in Medicine:
AMA-MSS will ask (1) That our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and (2) That our AMA encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals. (MSS Res 14, A-16) (Reaffirmed: MSS GC Report A, I-21)

Addressing Patient Spirituality in Medicine H-160.900
Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the

diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Medical Student Health and Well-Being H-295.927
The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 47
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Hailey Baker, University of Minnesota Medical School; Sarah Costello, University of Iowa Carver College of Medicine; Alwyn Mathew, Sam Houston State University College of Osteopathic Medicine; Canaan Hancock, Dell Medical School at UT-Austin; Michelle Troup, University of South Carolina School of Medicine Greenville; Jara Crawford, Indiana University School of Medicine; Alex Grayson, University of Cincinnati College of Medicine; Region 6: Rianna McNamee, Rowan School of Osteopathic Medicine, Anna Klunk, Philadelphia College of Osteopathic Medicine; Sandhya Sanapala, University of Connecticut School of Medicine

Subject: Federal Medical Assistance Percentage Extension for Urban Indian Organizations

Sponsored by: Region 1, Region 2, Region 3, Region 6, Student Osteopathic Medical Association, Association of Native American Medical Students, PsychSIGN

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The Center for Medicare and Medicaid Services (CMS) administers several important health programs to qualifying American Indian and Alaska Native (AI/AN) patients, such as Medicaid and Medicare[1]; and

Whereas, States are responsible for managing Medicaid programs and share the costs of these programs with the federal government[2]; and

Whereas, CMS frequently has special rules when working with the facilities serving the AI/AN population, including 100% Federal Medical Assistance Percentage (FMAP), year-long open enrollment periods, and employment exemptions[3]; and

Whereas, CMS reimburses states for a percentage of their total Medicaid expenditures at a variable FMAP, based on the state's per capita income[3,4]; and

Whereas, In all states, eligible services provided to AI/AN Medicaid enrollees at Indian Health Service (IHS) and Tribal Health Programs are reimbursed at 100% FMAP (i.e., state Medicaid program fully reimbursed for care)[3,4]; and

Whereas, In 2016, CMS expanded 100% FMAP for AI/AN Medicaid enrollees to also include services furnished by a non-IHS/Tribal physician if the services were first requested by an IHS/Tribal physician and a written care coordination agreement was in place[4,5]; and

Whereas, Urban Indian Organizations, facilities contracted with the Indian Health Service to provide healthcare for urban AI/AN people who do not reside on or near a reservation, were not

included in the 1976 amendments to the Social Security Act that originally extended 100% FMAP to services provided to AI/AN Medicaid enrollees at IHS/Tribal Health Programs[4]; and

Whereas, The American Rescue Plan Act of 2021 (ARPA) amended the Social Security Act to extend 100% FMAP to Medicaid enrollees seen by Urban Indian Health Programs for eight fiscal year quarters from 2021 through 2023[6]; and

Whereas, It is estimated that $70.4 million of Urban Indian Organization Medicaid costs will shift from 22 state government Medicaid accounts to the federal government during the Urban Indian Health Program 100% FMAP provision[4]; and

Whereas, The greatest cost-shifting for 100% FMAP expenditures due to ARPA will be in California, Montana, and Arizona (states with three or more Urban Indian Health Organizations)[4,6]; and

Whereas, If 100% FMAP for Urban Indian Organizations is extended past Fiscal Year 2023, around $547 million in costs over ten years will be shifted from states to the federal government[4]; and

Whereas, Congress has shown legislative interest in permanently extending 100% FMAP to services provided to AI/AN Medicaid enrollees at Urban Indian Organizations[4]; and

Whereas, Medicaid is an important federal health program for the AI/AN population, covering 36% of AI/AN adults under 65, compared to 22% of all U.S. adults[7]; and

Whereas, Every dollar saved by state Medicaid allows for greater health care service coverage for underserved populations; and

Whereas, Washington State currently reinvests 100% FMAP savings from Indian Health Service and Tribal health services (est. $16 million annually) into a tribally-driven health improvement fund ("Governor's Indian Health Advisory Council"), supporting AI/AN health and wellness services[8,9]; and

Whereas, 100% FMAP expansion for Urban Indian Organizations will not negatively impact appropriations and services at Indian Health Service and Tribal Health Programs[8]; and
Whereas, Approximately 70% of AI/AN adults reside in areas served by Urban Indian Organizations[8]; and

Whereas, Existing AMA policy, specifically "Improving Health Care of American Indians H-350.976," recommends that the federal government provide sufficient funds to support needed health services for American Indians and for state and local governments to give special attention to the health and health-related needs of nonreservation American Indians; therefore be it

RESOLVED, That our AMA will advocate for amendments to the Social Security Act that permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service; and be it further

RESOLVED, That our AMA will work with state medical societies to encourage state governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Cuts in Medicare and Medicaid Reimbursement H-330.932

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Rural Health H-465.989

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Extending Medicaid Coverage for One Year Postpartum D-290.974

Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children’s Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants.

Medicaid Expansion D-290.979

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will

advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

Medicaid Primary Care Payment Increases D-290.977

Our AMA: (1) advocates that the Affordable Care Act's Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as qualifying specialists, and support flexibility to achieve the best possible outcome; and (2) advocates for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact payment for any other physicians.

Extension of Medicaid Coverage for Family Planning Services H-75.988

The AMA supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women.

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984

1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.
2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 48
(A-23)

Introduced by: Joely Hannan, University of Washington School of Medicine, Matinder Dhillon, CHSU-COM; RJ Grewal, CHSU-COM; Julia Seiberling, University of California Riverside School of Medicine; Ursulina Tomczak, Creighton University School of Medicine; Swathi Bhuma, Chicago Medical School; Shruthi Bhuma, Chicago Medical School; Rohit Prasad, Dell Medical School at The University of Texas at Austin; Julia Houshmand, University of Miami Miller School of Medicine; Rishab Chawla, Medical College of Georgia; Joey Ballard, Indiana University School of Medicine; Maximilian Brockwell, Northeast Ohio Medical University; Carson Hartlage, University of Cincinnati College of Medicine; Michael Massey, Northeast Ohio Medical University; Hendrik Stegall, The Ohio State University College of Medicine; Donald Bourne, University of Pittsburgh School of Medicine; James Waters, Cooper Medical School of Rowan University; Constance Fontanet, Geisel School of Medicine at Dartmouth

Subject: Expanding AMA's Position on Healthcare Reform Options

Sponsored by: Region 3, Region 5, Region 6, Student Osteopathic Medical Association, PsychSIGN, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Our AMA-MSS supports the implementation of a national single-payer system (165.022MSS); and

Whereas, AMA policy states that “health care is a basic human right” and that “the provision of health care services… is an ethical obligation of a civil society.” (H-65.960); and

Whereas, AMA Principles of Medical Ethics states that “physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means” (11.1.4 Financial Barriers to Health Care Access); and

Whereas, AMA policy establishes “a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans” (H-165.904); and

Whereas, AMA policy supports health insurance coverage for all Americans (H-165.838); and

Whereas, AMA policy calls for improved health insurance affordability (H-165.824, H-165.828); and

Whereas, AMA policy supports the curtailment of surprise out-of-network billing (H-285.904); and

Whereas, AMA policy recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America (H-390.898); and

Whereas, Advancing health equity is a stated goal of the AMA (H-140.824, H-180.944); and

Whereas, AMA policy opposes excessive regulatory costs (H-155.974); and

Whereas, AMA policy supports reducing non-clinical health system costs that do not contribute value to patient care (H-155.960); and

Whereas, AMA policy supports programs whose purpose is to contain the rising costs of prescription drugs (H-110.997); and

Whereas, AMA policy supports federal medical liability reform and the inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform (H-435.978, D-435.974); and

Whereas, AMA policy supports streamlining the prior authorization process and reducing the overall volume of prior authorizations for physician practices (D-320.978); and

Whereas, AMA policy supports comprehensive reforms to reduce the administrative inefficiencies, costs, and burdens (H-155.976); and

Whereas, AMA policy states that “Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians” (H-373.998); and

Whereas, Evidence suggests that a single-payer health insurance system has the potential to address the above AMA policies via: elimination of uninsurance and underinsurance through universal coverage[1-3]; improved health insurance affordability and elimination of surprise bills through no out-of-pocket payments[1,4]; improved financing for physicians in rural areas through removal of systemic biases[5,6]; improved health equity through reduced disparities in health insurance coverage and health care access, with greatest relief to lower-income households[7-9]; improved prescription drug costs through drug price negotiations[10]; reduced tort claims because medical expenses would no longer be a major concern[11]; reduced prior authorization burden[12]; reduced administrative expenses[1-3,13]; expanded patient choice to choose any physician[3]; and

Whereas, Evidence suggests that a single-payer health insurance system has potential added benefits such as saving over 68,000 lives and 1.73 million life-years every year,[8] saving the health system billions annually,[14,15] having positive effects on the economy,[16] lowering the cost burden for lower- and middle-income households,[17] and even leading to increased physician wages[18]; and

Whereas, Single-payer health insurance is not a monolith, and the effects on the economy and individuals would depend on key features of the design of the program, such as how it paid clinicians and what services were covered[19]; and

Whereas, Our AMA is limited in its ability to meaningfully contribute to the design and implementation of any potential single-payer proposals due to its blanket opposition to single-payer financing mechanisms; and

Whereas, Other physician groups part of the AMA, such as the American College of Physicians,[20] American Medical Women's Association,[21] Hawaii Medical Society,[22] New Hampshire Medical Society,[23] Vermont Medical Society,[24] and Washington State Medical Association,[25] endorse a single-payer financing approach as an option to achieve universal coverage; and

Whereas, Evidence suggests that our AMA's stance against single-payer does not currently represent the majority of physicians, with surveys by Merritt Hawkins (56% either strongly support or somewhat support a single-payer system),[26] The Physicians Foundation (67% rate a two-tiered system featuring a single payer option plus private pay insurance as the best or next-best direction for the U.S. health care system),[27] and the Chicago Medical Society (66.8% have a "generally favorable" view of a single-payer financing health care system),[28] demonstrating broad support for single-payer health insurance; therefore be it

RESOLVED, That our AMA adopts a neutral stance regarding single-payer health insurance.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

National Healthcare Finance Reform: Single Payer Solution 165.020MSS
(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.
Citation: (MSS Res 12, A-17)

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Citation: (Res. 021, A-19; Reaffirmed: Res. 234, A-22)

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22)

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.
Citation: (Res. 717, I-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: CMS Rep. 2, A-22)

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
Citation: (BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14; Reaffirmed: CMS Rep. 09, A-19)

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Citation: Res. 118, I-91Res. 102, I-92BOT Rep. NN, I-92BOT Rep. S, A-93Reaffirmed: Res. 135, A-93Reaffirmed: BOT Reps. 25 and 40, I-93Reaffirmed in lieu of Res. 714, I-93Res. 130, I-93Res. 316, I-93Sub. Res. 718, I-93Reaffirmed: CMS Rep. 5, I-93Res. 124, A-94Reaffirmed by BOT Rep.1- I-94CEJA Rep. 3, A-95Reaffirmed: BOT Rep. 34, I-95Reaffirmation A-00Reaffirmation A-01Reaffirmed: CMS Rep. 10, A-03Reaffirmed: CME Rep. 2, A-03Reaffirmed and Modified: CMS Rep. 5, A-04Reaffirmed with change in title: CEJA Rep. 2, A-05Consolidated: CMS Rep. 7, I-05Reaffirmation I-07Reaffirmed in lieu of Res. 113, A-08Reaffirmation A-09Res. 101, A-09Sub. Res. 110, A-09Res. 123, A-09Reaffirmed in lieu of Res. 120, A-12Reaffirmation: A-17

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
Citation: Sub. Res. 203, I-09Reaffirmation A-10Reaffirmed in lieu of Res. 102, A-10Reaffirmed in lieu of Res. 228, A-10Reaffirmed: CMS Rep. 2, I-10Reaffirmed: Sub. Res. 222, I-10Reaffirmed: CMS Rep. 9, A-11Reaffirmation A-11Reaffirmed: CMS Rep. 6, I-11Reaffirmed in lieu of Res. 817, I-11Reaffirmation I-11Reaffirmation A-12Reaffirmed in lieu of Res. 108, A-12Reaffirmed: Res. 239, A-12Reaffirmed: Sub. Res. 813, I-13Reaffirmed: CMS Rep. 9, A-14Reaffirmation A-15Reaffirmed in lieu of Res. 215, A-15Reaffirmation: A-17Reaffirmed in lieu of: Res. 712, A-17Reaffirmed in lieu of: Res. 805, I-17Reaffirmed: CMS Rep. 03, A-18Reaffirmed: CMS Rep. 09, A-19Reaffirmed: CMS Rep. 3, I-21Reaffirmation: A-22

See also: Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care D-165.935; Individual Health Insurance H-165.920; Preferred Provider Organizations H-415.999; Reform the Medicare System D-330.924; Increasing Detection of Mental Illness and Encouraging Education D-345.994; Health System Reform Legislation H-165.838; Evaluating Health System Reform Proposals H-165.888

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 49
(A-23)

Introduced by: Medha Reddy, New York Medical College; Sarah Costello, University of Iowa Carver College of Medicine; Kimberly Hernandez, CUNY School of Medicine; Elizabeth Suschana, Julia Silverman, University of Connecticut; Madeline Holt, University of South Carolina School of Medicine Greenville; Rozena Shirvani, UT Rio Grande Valley; Sara Kazyak, Wayne State University School of Medicine, Region 5; Anastasia Rubakovic, Chicago College of Osteopathic Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine; Alissa Haas, Indiana University School of Medicine

Subject: Addressing Gender-Based Disparities on Health-Related Consumer Goods (The Pink Tax)

Sponsored by: Region 1, Region 2

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Gender-based pricing is a form of discrimination in which similar goods and services have different prices based on the consumer's gender[1]; and

Whereas, The current financial disadvantage women face due to lesser wages can be exacerbated by gender-based price disparities, with negative consequences for their health and well-being[2,3]; and

Whereas, Any arbitrary increase in the price of health-related goods marketed towards women would disproportionately disadvantage low income women[4,5]; and

Whereas, The 2015 New York City Department of Consumer Affairs study found that products marketed as women's products were more than twice as likely to be priced higher than men's products, with senior home health care products (i.e. supports, braces, canes and adult diapers) marketed towards women being priced 8% higher than those marketed towards men and the largest price disparity being 13% for personal care products (i.e. deodorants, body wash and razors)[6]; and

Whereas, This staggering disparity in gender-based consumer pricing suggests that a there is a tax on being a women consumer, which has colloquially known as the pink tax[4,7]; and

Whereas, The most comprehensive estimate of the overarching impact of the pink tax, conducted by the State of California in 1994, estimated that the pink tax on services alone cost women an extra $1,350 annually, which equates to roughly $2,135 in 2016[4]; and

Whereas, Transgender women and non-binary individuals face a high personal and social cost if they can only afford to use products targeted towards men[8,9]; and

Whereas, Section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)) defines an unfair or deceptive act or practice in or affecting interstate commerce as, "Two consumer products are substantially similar if there are no substantial differences in the materials used in the product, the intended use of the product, and the functional design and features of the product. A difference in coloring among any consumer products shall not be construed as a substantial difference…"[10]; and

Whereas, The United States currently has differing tariff rates on substantially similar men's and women's products, with on average higher tariff rates for women's goods[11,12]; and

Whereas, Gender-based pricing in services is already prohibited in New York City, Miami-Dade County, and the State of California and a national repeal had been introduced in the 117th Congress[13,14,15,16]; and

Whereas, While our American Medical Association (AMA) has recognized the existence of a sex-based tax in the consumer space in H-525.974 Considering Feminine Hygiene Products as Medical Necessities and H-270.953 Tax Exemptions for Feminine Hygiene Products H-270.953, gender-based disparities in the health-goods space extends far beyond feminine hygiene products including, but not limited to, goods such as supports, braces, canes, adult incontinence products (diapers, pads), plantar fasciitis insoles, and vitamins and supplements ; therefore be it

RESOLVED, That our AMA recognizes the existence of a gender-based disparity in health-related consumer goods; and be it further

RESOLVED, That our AMA will work with state medical societies to raise awareness of substantially similar health-related products that are priced differently based on the gender of the consumers and advocate for further regional study of this disparity.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Tax Exemptions for Feminine Hygiene Products H-270.953
1. Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA:

1. encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities;
2, will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; and
3. encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

Increasing Access to Hygiene and Menstrual Products H-525.973
Our AMA: (1) recognizes the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; (2) supports the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; (3) will advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance; and (4) encourages public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 50
(A-23)

Introduced by: Tanner Barone, Stacie Kerbel, Alekhya Madiraju, Phyllis Parkansky, Rithika Surenini, Lewis Katz School of Medicine

Subject: Utilizing Social Workers to Address and Prevent Gun Violence

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Annually 67,000 people are injured and hospitalized because of gun violence in the United States[1]; and

Whereas, In 2020, John Hopkins Center for Gun Violence reported there were 45,222 gun related deaths, with 4,368 of the deaths being among children and adolescents[2]; and

Whereas, There was a 32 percent increase in gun-related deaths from 2001 to 2020 with the number of deaths spiking from 2015 to 2020[2]; and

Whereas, The Kaiser Family Foundation reported that Black individuals were more likely to be killed by gun violence compared to a white individual with the age-adjusted rates per 100,000 being 31.8[3]; and

Whereas, The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard (145.001MSS); and

Whereas, Survivors are twenty times more likely to be involved in another gun-related injury compared to the general public[2]; and

Whereas, Some hospitals treat 400 to 600 gun violence victims per year with an average recidivism rate of 15 to 20% and 60 to 120 patients that are violently reinjured, costing the hospital 3 to 6 million dollars per year[4]; and

Whereas, Gun violence has a lasting impact on its victims and many feel unsafe and isolated following their injury, the need to carry a gun, and the need to normalize gun violence, practices that have led to recidivism among survivors[5]; and

Whereas, Gun violence survivors experience lasting mental health impacts, including post-traumatic stress disorder and depression and often return to the their communities without a mental health evaluation or emotional support[5]; and

Whereas, These survivors and their families have a unique emotional response to intentional gun violence and often live in an area with constant gun violence, increasing the risk of future acts of violence[6]; and

Whereas, Social workers have a previously established role in combating the effects of gun violence and are being hired by schools to prevent future school shootings because they are skilled at screening individuals for screening individuals at-risk for violence, addressing risk factors associated with violence, and crisis intervention[7]; and

Whereas, Hospital-based violence intervention programs (HVIP) collaborate with medical staff, including social workers and community partners to provide trauma-informed care to individuals that experienced gun violence[8]; and

Whereas, HVIP also provide support to the victim's family and other individuals that may have witnessed the violent act[8]; and

Whereas, The City of Philadelphia Public Health Department reported individuals enrolled in HVIP were less likely to report being a victim of violence 6 months after enrolling in HVIP programs and 85% of people with mental health challenges reporting their needs were met[8]; and

Whereas, "Turning Point," Temple University HVIP conducted a prospective randomized study from January 20212 to January 2014 and found that patients in the Turning Point program had a 50% reduction in aggressive response to shame, a 29% reduction in comfort with aggression, and a 19% reduction in overall proclivity to violence[9]; and

Whereas, Social workers are essential to the success of HVIP programs because they help to develop relationships with providers, potential employers for victims of violence, and community-based organizations[10]; and

Whereas, In addition to be able to connect victims and their families to community resources, hospital-based social workers are trained to recognize and respond patient mental health needs more efficiently than other, more generalized, health care professionals, leading to earlier interventions and improved mental health outcomes[11]; and

Whereas, The Medical College of Wisconsin's children hospital HVIP program social workers were placing 50% of the referrals to the program, the program had a goal of referring 70 percent of eligible participants to HVIP, but due to and social work turnover this goal was not met [12]; and

Whereas, At the University of Omaha social workers are being hired to reduce the rate of disenrollment and to bridge the gap between inpatient and outpatient community-based case

management, as they found that 38.89 percent of participants became inactive after an average enrollment time of 55.35 days and before meeting their short-term goals such as obtaining insurance and getting financial insurance[13]; and

Whereas, HVIP implemented at Rutgers's level one trauma center detailed that when 49% of gun violence victims were able to reach their goals through the help of social worker designated patient services within six months of being discharged, resulting in positive overall health outcomes[14]; and

Whereas, Existing policy from our AMA does encourage access to mental health and cognitive care for gun violence offenders, and emphasizes the management of mental illness in gun violence cases, and develop standardized approaches to mental health assessment for violent behavior (H-145.975); and

Whereas, Existing AMA-MSS policy does acknowledge that providers should deliver trauma informed care, of which one of the traumatic events may include gun violence (515.013MSS); and

Whereas, Existing AMA policy does address the importance of curbing gun violence and supports funding HVIP in communities, schools, hospitals, and clinics, there are currently no AMA policies that emphasize the social workers role in connecting gun violence victims to resources which reduce the associated health consequences; therefore be it

RESOLVED, That our AMA recognize the importance of social workers in hospital-based violence intervention programs and support more extensive research on the importance of having them as a core resource of hospital-based violence intervention programs.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992
Our AMA will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics; (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA’s efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics; (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA’s efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

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.

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.

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992
Our AMA will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics; (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

145.001MSS Handgun Violence
The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

515.013MSS Trauma-Informed Care Resources
AMA-MSS will ask the AMA to (1) recognize trauma-informed care, as defined by stakeholders as a practice that realizes the widespread impact of trauma on all patients, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeks to avoid retraumatization, and understands potential paths for recovery; and (2) support trauma-informed care by directing physicians to evidence based resources. (MSS Res 21, I-18) (AMA Res 526, A-19 [H-515.952])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 51
(A-23)

Introduced by: Jiwon Park, Moses Alfaro, Long School of Medicine at UT Health Science Center San Antonio; Isha Jhingan, The University of Oklahoma College of Medicine; Aaron Smith, University of Virginia School of Medicine; Pragi Patel, Ohio State University College of Medicine; Sherry Chen, University of South Carolina School of Medicine Greenville

Subject: Support for Persons with Skin-related Disorders and Disabilities

Sponsored by: Region 5, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The latest American Association of Dermatology (AAD) Burden of Skin Disease (BSD) published that 85 million Americans, consisting of 1 of 4 individuals in the U.S. population, were seen by a physician for a dermatologic disorder[1]; and

Whereas, In 2021 alone, 21,502 cases that qualified as “skin and subcutaneous tissue” disorders according to the Annual Statistical Report on the Social Security Disability Insurance (SSDI) Program[2]; and

Whereas, Despite the prevalence of skin disorders, stigmatization persists in patients with dermatologic conditions due to the visibility of affected skin, insufficient public understanding, and sociocultural factors[3]; and

Whereas, A conceptual model of the burdens of visible skin diseases (VSDs) demonstrated the impact of visible skin lesions on patients’ quality of life, such as anxiety, depression, low-self esteem, and prejudice from peers[4]; and

Whereas, Cosmetic involvement of disorders - in face, neck, and hands - independent of total body surface area (BSA) involvement can significantly increase patients' self-perceived stigma as well as contribute to negative self-image, exacerbating social isolation, depression, and suicidality[5-7]; and

Whereas, Skin conditions have strong psychophysiological aspects[8], yet their psychiatric and psychological comorbidity are under-recognized compared to systemic disorders - such as cardiovascular diseases and diabetes - despite the comparable quality of life impairments[4,9]; and

Whereas, Primary care physicians, predominantly in family medicine and internal medicine, see patients with cutaneous manifestations, especially due to the long wait time and post-referral process involved with seeing a dermatologist[10,11]; and

Whereas, A study showed that primary care physicians are aware of the psychosocial impacts of dermatologic disorders yet felt ill-equipped to address them[12-14]; and

Whereas, In a retrospective survey analysis of 8,876,767 adults with psoriasis, patients experiencing psychological distress or depression reported lower satisfaction with physicians[12], which addresses the importance of professions involved with dermatologic care - such as physicians, health and human professionals, and other relevant agencies - to recognize the unique burdens of dermatologic disorders; and

Whereas, Partnership between dermatology and psychiatry proved a valuable supplement to normal dermatological treatment and was followed by improvement in the majority of patients[15]; and

Whereas, There is a lack of research, standardization, and education on screening tools and interventions to identify patients with dermatologic disabilities that may experience psychiatric comorbidities[3,16]; and

Whereas, Despite dermatology resident physicians recognizing the need to screen for comorbid depression, most residents failed to conduct regular screening, and 64% noted that depression screening is not included in their curriculum or clinical practice[17]; and

Whereas, Identifying personality type may serve as a screening tool to identify at-risk patients that may benefit from stigmatization-related interventions[18]; and

Whereas, Beugen et al. identified patients with personality construct type D to be a predictor for higher self-perceived stigmatization due to their tendency of social inhibition suppressing emotional and behavioral expression to avoid negative public reactions - and frequent experiences of negative affect[19]; and

Whereas, Patients with dermatologic disorders like atopic dermatitis and psoriasis experienced higher rates of anxiety and depression alongside emotions of fear, anger, and declining self-esteem due to their reduced quality of life and chronic illnesses[20]; and

Whereas, The psychological aspects of acne vulgaris are associated with stress, type D personality, social phobia disorder (SAD), fear, anxiety, depression and suicidal thoughts/attempts, social or sexual dysfunction, reduced employment opportunities, and stigmatization[21]; and

Whereas, Considering that only 21.6%-31.2% of men and 16.9%-26.2% of established care primarily with their dermatologist and did not have visits with a primary care physician, there is a heightened importance for dermatologists to address comorbidities through mental health screenings and increased referrals to mental health treatment services[22]; and

Whereas, One study found a significant increase in age-standardized disability adjusted life years (DALYs) from 1990 to 2017 within the United States[23], where 1.79% of the total global burden of disease in DALYs came from over three hundred dermatologic conditions[24]; and

Whereas, The Americans with Disability Amendments Act (ADA) of 2008 defines disability to include physical impairments that substantially limit at least one major life activity including working via dysfunctions of the immune and/or integumentary system[25]; and

Whereas, The Social Security Administration (SSA) defines disability as an inability to engage in any substantial gainful activity because of medically determined impairment that has lasted for a continuous period of at least 12 months[26]; and

Whereas, SSA lists skin conditions for disability evaluations, including but not limited to ichthyosis vulgaris, bullous disorders, dermatitis, burns, genetic photosensitivity disorders, and hidradenitis suppurativa[27]; and

Whereas, SSA also includes disabilities with major cutaneous impairments that involve other organ systems, such as melanoma and tubular sclerosis complex[27]; and

Whereas, The Department of Veteran Affairs (VA) created the "Schedule for Rating Disabilities: Skin," in which these guidelines help define what skin conditions and associated severity of symptoms constitute disability coverage[28]; and

Whereas, Despite government-sponsored public assistance available through the SSA and VA[9,27], the general lack of medical training surrounding disability accommodation impacts dermatologists' ability to file dermatologic disability claims[29]; and

Whereas, The poor understanding of evaluation criteria for filing a disability claim, the time-intensive process of conducting a disability assessment, and the additional administrative burden discourage dermatologists to complete disability assessments for qualifying patients with dermatologic disorders[30]; and

Whereas, Cutaneous disability assessments are not covered by Medicare[30], which further increases barriers for qualifying patients from under-resourced, under-insured backgrounds to apply for disability assessments; and

Whereas, The American Academy of Dermatology (AAD) announced its three-year plan from 2021-2023 to expand diversity, equity, and inclusion in dermatology, which includes ensuring that dermatologic education and research encompasses health disparities and skin of color[31]; and

Whereas, Stigmatization is a societal problem, and educational interventions must improve public awareness of dermatologic disorders and disabilities to fundamentally resolve stigmatization, as supported by the AAD, Society for Investigative Dermatology, and American Society of Dermatopathology mission statements[9,31,32,33]; therefore be it

RESOLVED, That our AMA encourages physicians, health and human professionals, and other relevant agencies that involve persons with dermatologic conditions to recognize the unique burdens of dermatologic disorders due to the visibility of skin lesions, psychiatric and psychological comorbidities, and chronic, refractory disease course; and be it further

RESOLVED, That our AMA supports the inclusion of mental health screenings and increased accessibility to mental health treatment services, given the psychiatric and psychological comorbidities of dermatologic disabilities; and be it further

RESOLVED, That our AMA will work with the American Academy of Dermatology, Society for Investigative Dermatology, American Society of Dermatopathology, and public health organizations to improve awareness of cutaneous disability assessments as well as dermatologic disabilities, especially in under-resourced patients.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Social Security Disability Medical Benefits D-330.961
Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients, and will report and recommend further action to the House of Delegates as appropriate.

Medical Care of Persons with Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

Impairment and Disability Evaluations H-90.977
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.

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.

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990 1. Our AMA urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to: a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services; b) encourage students and trainees to avail themselves of any needed support services; and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.
3. Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested.
4. Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.
5. Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application.
6. Our AMA recommends adherence to the ADA recommendations in section 36.309 that requires the documentation requested by a testing entity to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of an examinee’s disability and their need for the requested testing accommodations, as noted by the Civil Rights Division of the Department of Justice in their 2014 interpretation of this ADA provision.
7. Our AMA will collaborate with key stakeholders to raise awareness regarding the process for applying and preparing for examinations, inclusive of requests for accommodations.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 52
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Melody Brown-Clark, Northwestern University Feinberg School of Medicine; Katie Wilson, University of Minnesota Medical School; Maddy Webber, University of Michigan Medical School; Brianna Baldwin, University of Virginia School of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine

Subject: Increasing Access to Colorectal Cancer Screening for American Indian / Alaska Native Populations

Sponsored by: Region 4, Region 7, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The incidence of early-onset colorectal cancer (diagnosis before age 50) is increasing, particularly in high-income countries such as the United States[1-2]; and

Whereas, From 2013 to 2017, colorectal cancer incidence was 41% higher for American Indian/Alaska Native (AI/AN) adults than non-Hispanic Whites among all age demographics[3]; and

Whereas, In the U.S., a greater proportion of AI/AN colorectal cancer cases are diagnosed in patients under age 50 when compared to non-Hispanic Whites (15.7% vs. 9.3%)[3]; and

Whereas, From 2013 to 2017, distant-stage colorectal cancer incidence in AI/AN adults was 51% higher than in non-Hispanic Whites[3]; and

Whereas, The incidence of early-onset colorectal cancer in AI/AN adults aged 20-49 years increased from 18.8 to 34.8 cases per 100,000 between the time periods of 1998-2002 and 2014-2018, one of the highest rates in the country[4]; and

Whereas, While overall colorectal cancer incidence has decreased between the time periods of 2005-2009 and 2013-2017 in both non-Hispanic Whites and AI/AN populations, the rate of decrease has been less in AI/AN populations (-0.5% vs -2.4%), and, in the Southwest region of the United States, AI/AN colorectal cancer incidence had increased by 2.9% [3,5]; and

Whereas, Indigenous Alaskans have the highest rates of CRC in the world (91.3 cases per 100,000)[13]; and

Whereas, The Alaska Native Tribal Health Consortium, the largest tribal health organization in the United States, recommends that Alaska Native men and women begin colorectal cancer

screening by age 40,[12] in contrast to the United States Preventive Services Task Force (USPSTF) recommendations of preventive colorectal cancer screening at age 45[6]; and

Whereas, In 2016, only 57.1% of AI/AN adults aged 50-75 fully met the USPSTF recommended colorectal cancer screening guidelines compared to 66.1% and 68.9% of African American and non-Hispanic White adults, respectively[7-8]; and

Whereas, In 2019, the Indian Health Service (IHS) found that only 31.5% of AI/AN patients served by the IHS underwent the appropriate colorectal cancer screening[9]; and

Whereas, In 2018, the IHS reported that Government Performance and Results Act (GPRA) colorectal cancer screening targets fell short of the 2018 GPRA target (of 32.6% screened) in 75% of their regional service areas, with the lowest in the California (23.4%) and Phoenix (25.8%) regional service areas[10]; and

Whereas, It has been recognized that there is a need for high-quality evidence on how to increase access to recommended colorectal cancer screening, follow-up, and treatment for AI/AN individuals, as well as culturally appropriate interventions[7]; and

Whereas, A $100,000 effort by the American Cancer Society to increase access to colorectal cancer screening at five organizations serving AI/AN individuals from 2017 to 2019 funded 11,700 evidence-based interventions, which led to 1,400 colorectal cancer screenings, 340 abnormal screenings, and a 10.1 percentage point increase in the colorectal cancer screening rate[9]; and

Whereas, In 2019, the U.S. Centers for Disease Control and Prevention, Indian Health Service, American Indian and Alaska Native-serving non-profit health organizations, and tribal epidemiology centers and health systems recommended (1) increasing the optimal IHS GPRA colorectal cancer screening target from 32.6 to 39%, (2) tribal-specific colorectal cancer intervention funding, (3) linking colorectal cancer screening to diabetes management efforts, and (4) direct mailing of fecal immunochemical tests (FIT) to screening eligible American Indian and Alaska Native households[9]; and

Whereas, In 2020, the U.S. Centers for Disease Control and Prevention and Albuquerque Area Indian Health Board concluded that a significant increase in CRC screening participation is possible in AI/AN communities by mailing FIT kits and instructions to eligible community members and providing easy options for returning the kits to the clinic[11]; and

Whereas, The AMA recognizes colorectal cancer as a leading cause of cancer death in the United States (H-55.981); and

Whereas, The AMA acknowledges the importance of coordinating with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45 (D-425.990); and

Whereas, The AMA recognizes the importance of encouraging colon cancer screening and improved patient awareness of guidelines particularly within minority populations and for all high-risk groups (D-55.998); therefore be it

RESOLVED, That our AMA will: (1) provide testimony in Congress for colorectal cancer prevention and intervention resources, including tribal technical assistance, to be directed to Indian Health Service, Tribal Health Programs, and Urban Indian Health Programs until colorectal Government Performance and Results Act (GPRA) screening measures are met; (2) encourage funding to be allocated to research the causes, prevention, and intervention regarding American Indian and Alaska Native colorectal cancer disparities and make these findings widely available; (3) establish partnerships with tribal organizations to conduct this research in a manner respecting Indigenous data sovereignty; and (4) lobby the Senate Committee on Indian Affairs and House Subcommittee for Indigenous Peoples of the United States in favor of funding the aforementioned research on the important issue of American Indian and Alaska Native colorectal cancer disparities; and be it further

RESOLVED, That our AMA will coordinate with interested national medical specialty societies, state medical associations, area Indian health boards, and relevant tribal advisory organizations to enhance physician education and awareness of the increased risk and need of screening for colorectal cancer among AI/AN patients, especially for those younger than age 50; and be it further

RESOLVED, That our AMA will work with relevant stakeholders to encourage distribution of colorectal cancer screening materials by rural and urban Indian health clinics and the Indian Health Service in an effective manner via culturally and linguistically competent resources, patient teaching time and culturally adapted follow-up interventions.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans H-185.960

1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests.

2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.

Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA D-425.990

Our AMA will coordinate with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45.

Carcinoma of the Colon and Rectum H-55.981

Our AMA supports: (1) Recognizing colon cancer as a leading cause of cancer deaths in the United States and encouraging appropriate screening programs to detect colorectal cancer. (2) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more

intensive screening efforts. (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that are available in this area. (4) Physicians engaging their patients in shared decision-making, including consideration of both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate.

Encourage Appropriate Colorectal Cancer Screening D-55.998

Our AMA, in conjunction with interested organizations and societies, will support 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 53
(A-23)

Introduced by: Veenadhari Kollipara, Himi Begum, Eleni Fafoutis, Courtney Landis, Pennsylvania State University College of Medicine

Subject: Support for Efforts to Maintain Construction/Building Safety Standards

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The purpose of the Occupational Safety and Health Administration (OSHA) is to help reduce construction-related injuries and deaths, and train workers in safe work practices, hazard recognition, and other aspects of safety[1]; and

Whereas, Six people died and 14 were injured from the fatal Building Collapse in Philadelphia in 2013 due to “a willful violation” by the contractors, which led to the sacrifice of workers and public safety[2]; and

Whereas, Six individuals died and one was injured during the Pedestrian Bridge Collapse at Florida International University in 2018 as a result of structural design deficiencies and ultimately, negligence of involved engineers[3]; and

Whereas, Three workers suffered fatal injuries and 18 workers suffered serious injuries in the New Orleans construction collapse in 2020 due to failure of recognizing hazards and implementing necessary safety measures[4]; and

Whereas, The 98 deaths from the Surfside Condominium Collapse in Florida in 2021 was a result of violation of building codes and the degradation of the building’s structural support[5]; and

Whereas, Higher rates of injuries against teenage workers occur at sites cited by OSHA as having safety violations[6,7]; and

Whereas, The injuries, mental harms, and fatalities were a result of violation of construction and building safety standards, and were all deemed as preventable deaths; and

Whereas, Maintenance and regulation would include the evaluation of electrical systems, plumbing, heating, ventilation, fire alarm, sprinkle system and smoke detection systems, along with stringent monitoring and quality control during construction of homes, public infrastructure, and private infrastructure[8,9]; and

Whereas, safety trainings in a variety of modes, including narratives and virtual reality, have the potential to prevent accidental deaths in the construction workforce[10,11]; and

Whereas, Existing AMA policy supports high standards for “standards for the construction and maintenance of roads and highways” (Automobile-Related Injuries H-15.990); and

Whereas, Existing AMA policy supports enacting “fire protection codes in public buildings” (Better Fire Prevention in Public Buildings H-10.989); therefore be it

RESOLVED, That our AMA encourages construction industry employees to receive training in building safety, and establishing better reporting channels and mechanisms in collaboration with Occupational Safety and Health Administration (OSHA) to reduce the mortality due to preventable deaths.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Better Fire Prevention in Public Buildings H-10.989
The AMA urges state public authorities to enact uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at

least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors.

Public Health Hazards Associated with Landscaping Services D-135.986
Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect & grub control, tree & bush care, debris removal, fence, driveway, rock garden & stone path construction requiring use of saws, and a full spectrum of motorized equipment).

Tornado Safety and Manufactured Homes H-130.936
Our AMA believes that:
1. Owners of manufactured home parks should provide a plan, developed with and approved by local authorities, for the evacuation and sheltering of residents of the park in severe weather events such as tornadoes, high winds, or floods. The plan should advise residents of the vulnerability of manufactured homes in tornadoes and other extreme wind events and that evacuation to a safer location is necessary. The shelter or evacuation plan should be posted conspicuously in the park and the park owner should provide each resident with a copy of the approved shelter or evacuation plan.
2. State and local government authorities in regions at increased risk for tornadoes and other extreme wind events should enact measures to either provide, or require owners of manufactured home parks in their jurisdiction to provide, as appropriate, an approved common storm shelter or safe room for all residents of manufactured homes in the park as protection against tornadoes and other extreme wind events.
3. Research is needed to enhance the design and construction of manufactured homes and manufactured home tie down/anchoring systems to withstand extreme wind forces and wind-blown debris.
4. Federal, state, regional, and local authorities should coordinate policies, processes, and procedures to ensure that manufactured homes are installed and inspected in accordance with established guidelines and standards, including requirements for the installation and inspection of tie down/anchoring systems.
5. Incentives should be developed for all homeowners (including those who live in manufactured homes), businesses, and local governments in regions at increased risk for tornadoes and other extreme wind events for the installation of home or community safe rooms and storm shelters, in accordance with federal and professional guidelines and standards.
6. All citizens should consider purchasing a NOAA Weather Radio All Hazards public alert radio for use in disasters and other emergency situations. Citizens also should develop a plan for where they will go and what they will do when a severe weather alert is issued.

Automobile-Related Injuries H-15.990
Our AMA:
(1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries.
(2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal.
(3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles.
(4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children.

(5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes.
(6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement.
(7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention.
(8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams.
(9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions.
(10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior.
(11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers.
(12) Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption.
(13) Will work with interested state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.
(14) Our AMA will encourage the National Highway Traffic Safety Administration to undertake the necessary rulemaking to integrate automated high-beam to low-beam headlight switching lamps into the Federal Motor Vehicle Safety Standards.
(15) Our AMA will support more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 54
(A-23)

Introduced by: Thomas J. Johnson, Elizabeth P. Darga, Stephen T. Tryban, Emily A. Ridge, Central Michigan University College of Medicine; Rajadhar Reddy, Baylor College of Medicine; Justin Magrath, Tulane University School of Medicine; John Preston Wilson, Louisiana State University Health Sciences Center Shreveport School of Medicine; Krishna Channa, University of Connecticut School of Medicine, Jack Reifenberg, University of Cincinnati College of Medicine

Subject: Reconsideration of Medical Aid in Dying

Sponsored by: Region 1, Region 2, Region 3, Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The practice that our AMA calls as “physician-assisted suicide” (PAS) is often referred to by many other terms, including “medical aid in dying” (MAID)[1]; and

Whereas, The American Psychological Association and the American Association of Suicidology recognize that “suicide” is distinct from MAID, and the use of “suicide” to describe MAID may misrepresent and stigmatize patients’ rationale and choices[2]; and

Whereas, In jurisdictions where it is legal, MAID allows adults with terminal illness and preserved decision-making capacity to request a prescription for self-administered medications to end their life, while retaining the autonomy to decide when to fill the prescription and when to self-administer the medication[1]; and

Whereas, Medical aid in dying (MAID) is legal by legislation, judicial action, or referendum in eleven US jurisdictions, covering 1 in 4 US adults: California (2015), Colorado (2016), Hawaii (2018), Montana (2009), Maine (2019), New Jersey (2019), New Mexico (2021), Oregon (1994), Vermont (2013), Washington state (2008), and Washington, DC (2016)[3-4]; and

Whereas, Our HOD last considered neutrality on MAID over three meetings at A-18, I-18, and A-19, extensively debating and ultimately maintaining our existing ethical opinion that “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”; and

Whereas, According to a 2020 Medscape Survey, 55% of physicians (including 51% of primary care physicians and 57% of specialists) support legalization of MAID[5], indicating that a position

of neutrality instead of opposition would more accurately represent the profession of medicine; and

Whereas, Removing and/or deciding not to provide life-sustaining medical care including a respirator, feeding tube, antibiotics, and cancer treatment are legal in the United States and utilized as methods to facilitate ending the life of a terminally ill patient[6]; and

Whereas, Cancer patients who have decided to forgo treatment and accept death can experience considerable pain as they wait for their disease to end their life[7-8]; furthermore, family caregivers feel burdened with managing end-of-life pain[9]; and

Whereas, Death by the removal of a feeding tube can take over ten days and cause anxiety for loved-ones, which is sometimes reinforced by dramatic physical alterations induced by starvation[10]; and

Whereas, Leading ethical scholars have concluded that letting die in many circumstances is more cruel than allowing a patient to actively end their own life[11]; and

Whereas, In 2016, the American Academy of Hospice and Palliative Medicine took a position of "studied neutrality on the subject of whether [physician-assisted dying] should be legally permitted or prohibited," while continuing to maintain concerns over its use in routine medical practice and the maintenance of appropriate safeguards[5]; and

Whereas, In 2018, the American Academy of Neurology "decided to retire its 1998 position…and to leave the decision of whether to practice or not to practice [lawful physician-hastened death] to the conscientious judgment of its members acting on behalf of their patients…mak[ing] no attempt to influence an individual member's conscience in consideration of participation or nonparticipation"[12]; and

Whereas, In 2018, the American Academy of Family Physicians adopted a "position of engaged neutrality toward medical-aid-in-dying as a personal end-of-life decision in the context of the physician-patient relationship" by a two-thirds vote[13]; and

Whereas, Despite concerns over the misuse of MAID for patients from minoritized communities, research on racial inequities in end-of-life care actually indicate that non-white patients are less likely to complete advance care plans or be asked their preferences [14-17] and that white patients are more likely to use MAID and safeguards in MAID laws make abuse of the law difficult[8]; and

Whereas, While concerns may exist regarding patients choosing MAID over continuation of care on financial grounds, patients already choose between hospice and continuation of care, which may hold similar financial considerations[18]; and

Whereas, *Gideonse v Brown* (2022) found that patients can legally travel to Oregon from jurisdictions where MAID is illegal, meaning that physicians across the US may potentially encounter a patient interested in pursuing this service[19]; and

Whereas, During the last HOD debate on MAID, our MSS Caucus supported neutrality; and

Whereas, Our MSS currently "recognizes that situations may exist where it would be ethically acceptable for patients to choose to end their own lives" (140.026MSS) and "supports protections for physicians who participate in physician aid-in-dying in states where physician aid-in-dying is legal" (140.034MSS), but does not take a stance on supporting MAID and does not address euthanasia; and

Whereas, MAID requires patients to self-administer medications, which is not an option for some patients with mobility impairment[20]; and

Whereas, Patients who want MAID but are unable to self-administer medications would require assistance to exercise their autonomy, which would qualify as euthanasia and therefore be illegal across the US[20]; and

Whereas, Access to MAID without access to euthanasia may adversely influence some patients to end their lives earlier than ideally desired, while they can still self-administer medications[20]; therefore be it

RESOLVED, That our AMA-MSS support access to medical aid in dying (MAID) for adults with terminal illness and preserved decision-making capacity; and be it further

RESOLVED, That our AMA-MSS support access to euthanasia for adults with terminal illness and preserved decision-making capacity who cannot self-administer medications; and be it further

RESOLVED, That our AMA-MSS support health coverage that comprehensively and equitably funds all medically appropriate end-of-life care legal in a jurisdiction (including palliative and hospice care, continuation of nonfutile care until death, MAID, and euthanasia) to remove financial barriers to patient autonomy; and be it further

RESOLVED, That our AMA-MSS amend 140.034MSS, "Physician Aid-in-Dying," by addition and deletion to read as follows; and be it further

> **140.034MSS ~~Physician~~ Medical Aid-In-Dying Protections & Terminology**
> AMA-MSS (1) supports protections for physicians and other health professionals who participate in ~~physician~~ medical aid in dying and (2) encourages use of the term "~~physician~~ medical aid in dying" instead of "physician-assisted suicide."

RESOLVED, That our AMA-MSS rescind 140.026MSS, "Assisted Suicide," as it is superseded by this resolution; and be it further

RESOLVED, That our AMA oppose criminalization of physicians or other health professionals who engage in medical aid in dying or euthanasia at a patient's request and with their informed consent; and be it further

RESOLVED, That our AMA oppose civil or criminal legal action against patients who request or attempt to engage in medical aid in dying or euthanasia; and be it further

RESOLVED, That our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions; and be it further

RESOLVED, That our AMA rescind H-270.965, "Physician-Assisted Suicide," regarding advocacy opposing legalization of physician-assisted suicide and euthanasia.

Fiscal Note: Minimal

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RELEVANT AMA AND AMA-MSS POLICY

Code of Medical Ethics Opinion 5.7 Physician-Assisted Suicide

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully

expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.
Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.
Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.
AMA Principles of Medical Ethics: I,IV

Code of Medical Ethics Opinion 5.7 Euthanasia
Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.
It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.
However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.
Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.
The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that a cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.
Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18

Physician Assisted Suicide H-140.952
It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.

(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.
CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmed: CEJA Rep. 03, A-19

Decisions Near the End of Life H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.
(5) Our AMA supports continued research into and education concerning pain management.
CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed in lieu of Res. 211, I-13; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 55
(A-23)

Introduced by: Justin Magrath, Tulane School of Medicine; Raj Reddy, Baylor College of Medicine

Subject: Carbon Pricing to Address Climate Change

Sponsored by: Region 3, PsychSIGN

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A meta-analysis of global systemic risk associated with climate change found that 1,546 papers between 1989 and 2013 indicated that there is a direct link between environmental change and negative health risks[1]; and

Whereas, the World Health Organization estimates that climate change-related disease, including malnutrition, malaria, diarrhea, and heat stress, could cause approximately 250,000 additional deaths per year from 2030 to 2050[2,3]; and

Whereas, According to the National Institute of Environmental Health, the most common non-communicable chronic diseases (NCDs)—heart disease, stroke, cancer, diabetes, and respiratory diseases, which account for 60% of the 58 million global annual deaths—are significantly exacerbated by climate change[4-6]; and

Whereas, A meta-analysis representing 3,933,398 elderly mortality cases from 1980 to 2010 found that a 1°C temperature rise increased cardiovascular mortality by 3.44%, respiratory mortality by 3.60%, and cerebrovascular mortality by 1.40%[7]; and

Whereas, The 5th Assessment Report of the Intergovernmental Panel on Climate Change concluded that "human influence on the climate system is clear" and "recent climate changes have had widespread impacts on human and natural systems[8.9];" and

Whereas, Atmospheric concentrations of the greenhouse gas carbon dioxide are directly linked to climate change[10-13]; and

Whereas, Carbon pricing is a method which places a price on carbon dioxide emissions to account for negative externalities, thus providing an economic incentive to reduce greenhouse gas emissions[14]; and

Whereas, William Nordhaus was awarded the 2018 Nobel Prize in Economics for his work demonstrating that world-wide carbon pricing with full international participation is the most efficient and effective method to reduce greenhouse gas emissions[15-22]; and
Whereas, Nordhaus's modeling demonstrates it would cost 2.5x as much to reduce carbon emissions if only half of the world's carbon emitters participated"[18]; and

Whereas, The Economists' Statement on Carbon Dividends signed on Janurary 17, 2019 by 3508 economists including 4 Former Chairs of the Federal Reserve, 15 Former Chairs of the Council of Economic Advisors, and 28 Nobel Laureate Economists states that "a carbon tax offers the most cost-effective lever to reduce carbon emissions at the scale and speed that is necessary;"[23] and

Whereas, Carbon pricing not only reduces carbon emissions, but also reduces other forms of harmful air pollution and creates a revenue stream that can be returned to citizens to promote health equity, used to improve energy efficiency, and/or invested in renewable energy research; [21,23-26,40], and

Whereas, The two primary carbon pricing systems are a carbon tax and cap-and-trade[18,19,27]; and

Whereas, The Stanford Energy Modeling Forum conducted a study using 11 economic models, all of which found that a carbon tax would substantially reduce greenhouse gas emissions and would decrease the economic growth rate by a maximum of only 0.1%[28]; and

Whereas, Ireland implemented a carbon tax system which has led to an emissions drop of 15% since 2008, including a 6.7% decrease in 2011 emissions as the economy grew[29-32,42]; and

Whereas, Australia implemented a carbon tax in 2012 and saw a sharp decline in the electric-sector carbon emissions and a decrease in brown and black coal use, while a subsequent repeal of the tax in 2014 immediately produced an undesirable upturn in carbon emissions and a rebound in coal usage[33-35]; and

Whereas, California has established a cap-and-trade system that independently regulates CO_2 emissions, increases utilization of alternative energy, and enabled California to reduce its CO_2 emissions to 1990 levels 4 years ahead of its original 2020 goal[24,26,36,39]; and

Whereas, The Regional Greenhouse Gas Initiative (RGGI) is a cap-and-trade system among twelve states in the northeastern United States which led to an economy-wide drop in CO_2 emissions of 35% between 2009 and 2014 as compared to a 12% drop in CO_2 emissions in non-RGGI states[24,37]; and

Whereas, Fifty-two national or regional governments, constituting 19.5% of global greenhouse gas emissions, have either implemented or are scheduled to implement a carbon pricing initiative[24,38,41]; and

Whereas, Our AMA "supports initiatives to promote environmental sustainability and other efforts to halt global climate change" (H-135.923, AMA Advocacy for Environmental Sustainability and Climate); and

Whereas, Our AMA "will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting" (D-135.966, Declaring Climate Change a Public Health Crisis); and

Whereas, Our AMA "recognizes the importance of physician involvement in policy-making 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" (H-135.938, Global Climate Change and Human Health); therefore be it

RESOLVED, That our AMA amend D-135.966 by addition and deletion to read as follows:

Declaring Climate Change a Public Health Crisis D-135.966

Our AMA:

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
4. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change.
5~~3~~. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. Res. 924, I-16

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
CSAPH Rep. 3, I-08 Reaffirmation A-14

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

Climate Change and Human Health D-135.963
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid

implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
CSAPH Rep. 2, I-22

Global Climate Change - The "Greenhouse Effect" H-135.977
Our AMA:
(1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population.
CSA Rep. E, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmation A-12 Reaffirmed in lieu of Res. 408, A-14

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family

planning through national and international support. CSA Rep. G, I-89 Amended: CLRPD Rep. D, I-92 Amended: CSA Rep. 8, A-03 Reaffirmed in lieu of Res. 417, A-04 Reaffirmed in lieu of Res. 402, A-10 Reaffirmation I-16

135.012MSS Toward Environmental Responsibility
AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 56
(A-23)

Introduced by: Pritika Parmar, Olumide Fajolu, Haider Sarwar, University of Colorado School of Medicine; Darby Billing, University of South Carolina School of Medicine Greenville; Jacob Rha, Tufts University School of Medicine; Kristina Pieterson, University of Arkansas for Medical Sciences College of Medicine

Subject: Expanding the Use of Medical Interpreters

Sponsored by: Region 1, Association of Native American Medical Students, PsychSIGN, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The US Census Bureau reported that nearly 5 million (4% of total) U.S households have zero English speaking adults and are considered limited English proficiency households[1]; and

Whereas, Those with Low English Proficiency (LEP) reported having increased negative experiences in primary care offices when compared to those proficient in English with outcomes including longer wait times, greater difficulty obtaining information or advice by phone, and less continuity of care[2]; and

Whereas, In a systematic review exploring the impact of language-concordant care on a patients' quality of care, satisfaction with care, medical understanding, and mental health, 76% of studies demonstrated that at least one of the outcomes assessed was better for patients receiving language concordant care[3]; and

Whereas, The use of interpreters has independently been associated with increased satisfaction with provider communication, healthcare satisfaction, morbidity and mortality benefits, increased health literacy, and fewer malpractice lawsuits[3]; and

Whereas, Language-concordant patients had 15% increase in glycemic control compared to their language-discordant peers[4]; and

Whereas, LEP patients with access to professional interpretation compared to no interpreter use had 7.1 increased odds of receiving complete discharge education and 6.1 greater odds of high quality assessment of caregiver comprehension[5]; and

Whereas, Increasing access to interpretation services decreased hospital readmission rates, associated with an estimated monthly hospital expenditure savings of $161,404, after accounting for interpreter services costs[6]; and

Whereas, According to a systematic review exploring the outcomes of text message reminders, nearly all the short message service (SMS) reminder studies helped improve patient compliance, especially when delivered in the patient's preferred language[7]; and

Whereas, The implementation of reminder messages in both English and Spanish was found to increase the show rate by 13.6% overall[8]; and

Whereas, Pre-visit phone calls by volunteer bilingual patient navigators is strongly associated with improved appointment attendance[9]; and

Whereas, NYC Health and Hospital systems began providing appointment reminder translations in 14 commonly used languages in 2020 and successfully reduced missed appointments by 6.1%[10]; and

Whereas, Consistent preventative and non-preventative appointment attendance is crucial to the maintenance of health and has shown the potential to improve long-term health outcomes in minority groups;[12,13] and

Whereas, Most Medicaid programs pay physicians $30 to $50 per office visit and interpretation services cost between $30 and $400, meaning that some providers lose money by seeing LEP patients[14]; and

Whereas, Less than 70% of all US hospitals offer language concordant care, partly due to the financial burden of having to fund these services on their own;[15] and

Whereas, Policy D-385.957 works to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act, and advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates; and

Whereas, Policy H-385.917 supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services; and

Whereas, Policy D-160.992 seeks legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English, and require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care; and

Whereas, Policy D-385.978 works to obtain federal funding for medical interpretive services, remove the financial burden of medical interpretive services from physicians, urges the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; and

Whereas, Policy 160.042MSS recognizes the importance of using medical interpreters, encourages physicians and physicians in training to improve interpreter-use skills and increase education, and work with relevant stakeholders to develop educational resources; and

Whereas, Existing policy focuses on education surrounding the use of interpreter services and funding within the medical encounter; existing policy does not discuss interpretation provided before and after the encounter, including reminder calls and messages or post-appointment summaries; therefore be it

RESOLVED, That our AMA supports the expansion of interpreter services to include providing appointment reminder calls/messages, post-appointment summaries, electronic medical records, and any other documentation or communication in the patient's preferred language by professional medical translators; and be it further

RESOLVED, That our AMA advocates on a national level for the incorporation of these expanded interpreter services and supports an increase in hospital reimbursement of interpretation costs by the Centers for Medicare and Medicaid Services to ensure access to quality interpretation services for all patients.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Support for Standardized Interpreter Training D-300.976

1. Our AMA encourages physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services".
2. Our AMA will work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module

offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

Physician Reimbursement for Interpreter Services D-385.946
1. Our AMA will prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services.
2. Our AMA will continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services.

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
1. Our AMA (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

Patient Interpreters H-385.928
1. Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

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

Interpreter Services and Payment Responsibilities H-385.917

1. Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

Appropriate Reimbursement for Language Interpretive Services D-160.992

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Discrimination Against Physicians by Health Care Plans H-285.985

1. Our AMA will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans.
2. Our AMA will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans.
3. Our AMA will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need.
4. Our AMA encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse.
5. Our AMA urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.

Interpreters for Physician Visits D-90.999

1. Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929

1. Our AMA will to the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice/
2. Our AMA will continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.

Language Interpreters D-385.978

1. Our AMA will continue to work to obtain federal funding for medical interpretive services.
2. Our AMA will redouble its efforts to remove the financial burden of medical interpretive services from physicians.
3. Our AMA urges the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement.
4. Our AMA considers the feasibility of a legal solution to the problem of funding medical interpretive services.
5. Our AMA works with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

160.017MSS Study of Interpreter Mandate

AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English. MSS Res 20, I-10

160.034MSS Improving Language Access for Limited English Proficiency Patients AMA-MSS supports initiatives to educate physicians and medical students on the appropriate use of medical interpreters. MSS Res 32, I-16

160.036MSS Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings

AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, in the stead of patient family members and friends. MSS Res 06, A-17

160.042MSS Support for Standardized Interpreter Training

Our AMA-MSS will ask the AMA to: (1) recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments; (2) encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC “Guidelines for Use of Medical Interpreter Services”; and (3) work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian AMA-MSS Digest of Policy Actions/ 85 Physicians, National Association of the Deaf, and other relevant stakeholders to develop educational resources, such as through

the AMA Ed Hub, for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. MSS Res. 123/CME MIC Rep. A

310.055MSS Improving Support and Assistance for Medical Students with Disabilities

AMAMSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM). MSS Res 3

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 57
(A-23)

Introduced by: John Preston Wilson, LSUHS School of Medicine; Whitney Stuard, UTSW; Ida Vaziri, UT Health San Antonio; Rajadhar Reddy, Baylor College of Medicine

Subject: Inappropriate Use of Health Records in Criminal Proceedings

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, According to a Department of Justice (DOJ) a study of state inmates demonstrated 43% of incarcerated individuals have a current medical problem, with 64.4% of illnesses documented attributable to chronic disease[2], and Greater than 50% of those incarcerated in the United States have a mental health disorder including, but not limited to, mania, depression, and psychotic disorders[1,2,3,4]; and

Whereas, AMA policies H-430.985 and H-430.986 strongly advocate for healthcare for individuals who are incarcerated, including supporting the use of public insurance (Medicaid, CHIP, Medicare) and the removal of copays for those incarcerated; and

Whereas, Patients in jails or prisons have been found to seek treatment for these discussed chronic conditions at lower rates than the general population, with the 2004 DOJ finding only 69.7% of the inmates with current conditions having received medical treatment. Finding a large gap between those who need treatment, and those receiving[4]; and

Whereas, The American Journal of Public health found that 20% of state and 68% of jail inmates did not receive routine medical examinations not attributable to lack of access of care. [5]; and

Whereas, This discrepancy in distributed medical examinations is known to be in part due to those incarcerated avoiding adding additional unnecessary paperwork to their parole portfolio; and

Whereas, Discrepancies in inmates with medical illness and inmates who received treatment for their current illness are not attributable to lack of access to care being that coverage is provided by on site medical staff or combined public/private medical teams[3]; and

Whereas, People who are incarcerated and seeking parole go through a variable state dependent process that is based on that state's justice department policies and procedures[7]; and

Whereas, For parole hearings a patients' history based on arbitrary factors play into parole decisions such as the person's criminal background, nature of the offense, risk assessment, victim impact, and others[6]; and

Whereas, There have been many extraneous factors identified outside of the realm of variables directly related to the person's criminal background, and pertinent information related to the incriminating offense that can affect an incarcerated individual's chances of favorable outcome in these situations. Including, but not limited to: the time of day that the parole board reviews the criminal's case, the age of the individual being reviewed, and the ethnicity and race of the individual.[7,8]; and

Whereas, It has been shown in certain states that extensive medical management resulting in large stacks of paperwork for the parole board to review can negatively impact the diligence attributed to sifting through these documents leading to an unjust decision[9,10]; and

Whereas, Parole board hearings that include the illegitimate use of health records of these patients, specifically in instances where inclusion of the healthcare documentation is not pertinent to the criminal's case history, behavior while incarcerated, or any other unforeseen circumstances that could be considered as relevant in the decision making process of granting parole to these individuals. Negatively impact their chances of seeking a fair decision in being granted parole by parole boards, specifically, in those diagnosed with illness requiring extensive medical management to address their needs, such as autoimmune conditions, metabolic disorders, and neuropsychiatric illnesses[9,10]; and

Whereas, Medical management requiring extensive observation, identification of optimal pharmacology, testing, or even regular therapy sessions are instances that can lead to an extensive health documentation history. Instances where prisoners are granted compassionate release this documentation is useful. However, instances where a prisoner is seeking a parole decision outside of compassionate release circumstances can be negatively impacted. Due to large prisoner parole portfolio application packets presenting increased workload to parole boards. Leading to a decrease in diligence assigned to identifying pertinent versus unrelated health history documentation[11]; therefore be it,

RESOLVED, That our AMA oppose the automatic inclusion of health records without informed consent to lengthen parole board portfolio packets and adversely influence parole decisions due to documentation volume; and be it further

RESOLVED, That our AMA support the inclusion of physician oversight in decisions to include health records in parole portfolio application packets; and be it further

RESOLVED, That our AMA collaborate with the American Bar Association, state and county medical societies, and other interested stakeholders on efforts to improve adequate review of health history to determine relevance of inclusion in parole portfolio application packets, preventing unforeseen consequences arising from unnecessary health record inclusion.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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.
Res. 021, A-19; Reaffirmed: Res. 234, A-22

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.
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

Compassionate Release for Incarcerated Patients H-430.980
Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.
BOT Rep. 10, I-20

Patient Privacy and Confidentiality H-315.983
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should

be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 58
(A-23)

Introduced by: Justin Magrath, Tulane School of Medicine; Raj Reddy, Baylor College of Medicine; Samantha Pavlock, Florida State University College of Medicine

Subject: A Public Health-Centered Criminal Justice System

Sponsored by: Region 2, Region 3, Region 4

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Health Impact of Incarceration:

Whereas, The United States is the nation with the highest percentage of incarcerated individuals, with an incarceration rate of 655 per 100,000 and over 2.1 million people in prison in 2018[1]; and

Whereas, The number of people imprisoned for a violent crime increased by 300% between 1980 and 2009 despite the number of murders per capita staying relatively constant[2,3]; and

Whereas, The U.S. criminal justice system results in significant adverse impacts on individual and community health during and after incarceration[4,5]; and

Whereas, People who are incarcerated in the U.S. have higher rates of nearly every infectious disease compared with the general population, including HIV, tuberculosis, hepatitis C virus (HCV) I, and COVID-19 infection rates more than 5x higher than the general U.S. population[6-8]; and

Whereas, Incarcerated individuals in the U.S. also show an increased presentation of symptoms or diagnosis of psychiatric illness nearly 4x the rate of the overall U.S. adult population[9,10]; and

Whereas, Solitary confinement, being assaulted while incarcerated, lack of social interaction, crowded conditions, and reduced healthcare access all lead to poor physical and mental health outcomes while being incarcerated[11-14]; and

Health Impacts After Incarceration:

Whereas, Previously incarcerated individuals face a 3.5x greater risk of death within the first 2 years after release, and are 129x more likely to die due to a drug overdose within the first 2 weeks than those who have not previously been incarcerated[15]; and

Whereas, Formerly incarcerated youth as well as adults have increased rates of chronic medical conditions, sexually transmitted infections, substance abuse disorders, and mental health disorders[16-18]; and

Whereas, Previously incarcerated individuals are 5x less likely to be employed, with 60% unemployed one year after release, as well as 3x more likely to be uninsured, and face significant barriers in acquiring education, stable housing, and support for mental health[19]; and

Whereas, The burdens of mass incarceration have been disproportionately borne by black communities and other minorities due to factors such as racially-motivated policing and race-based discrimination in jury-selection[25-29]; and

Whereas, As of September 2020, 46.1% of federal inmates were imprisoned due to drug offenses; and racial minorities are more likely to be arrested for drug- and alcohol-related crimes, and were more likely to be arrested, convicted and imprisoned rather than cited and released at both the felony and misdemeanor levels, findings that hold true in every U.S. state[30]; and

Overburdening the Criminal Justice System:

Whereas, As high as 45% of the prison population are held due to violation of parole or other technical violation rather than violent offense contributing to overcrowding issues, particularly at state prisons[31]; and

a. Mandatory Minimums:

Whereas, Mandatory minimums are defined as laws requiring judges to sentence offenders to a pre-specified minimum incarceration term for a particular crime[32,33]; and

Whereas, Mandatory minimums have not shown to be effective in decreasing crime, with a 2018 analysis examining the use of cocaine base and powdered cocaine following the implementation of mandatory minimum policies found no decrease in cocaine base use after the implementation of such policies, despite the harshest penalties being imposed for cocaine base use[33]; and

Whereas, Mandatory minimum sentences fail to effectively deter crime and result in long periods of incarceration that are associated with increases in recidivism[32, 34]; and

Whereas, Racial inequities in the application of mandatory minimum sentences are driven in part by disparities in the types of offenses to which mandatory sentences are applied (including drug-related charges and particularly repeat offenses), but also are due to inequities in the application and enforcement of the mandatory sentences via prosecution, with Black defendants being more likely than White defendants to be subjected to the mandatory minimum sentence even among those convicted of the exact same charges[35-37]; and

Whereas, Because under mandatory minimums, conviction is required and standardized once an individual is found guilty, the enforcement of minimums is dependent on prosecutors' willingness to prosecute individuals, thus shifting discretionary power from judges (judicial discretion) to prosecutors (prosecutorial discretion), who can be perceived as “less neutral court actors”, thus contributing to the demographic and racial inequities exacerbated by mandatory minimum sentencing[38]; and

b. Three Strikes Rules

Whereas, Sentencing policies known as “three-strikes” policies, which are termed habitual offender laws were first implemented in the 1990’s as part of the U.S. Anti-Violence Strategy, refer

to laws that significantly increase the sentence of a felony if a person has been convicted of 2 or more felonies previously[39-41]; and

Whereas, In some states, one incident can result in an individual being charged for multiple felonies, and receive all three strikes all at once[39]; and

Whereas, Three-strikes policies consistently fail to reduce recidivism, generate massive economic burden, and further derelictions of duty to rehabilitate and reintroduce offenders to society after long sentences[39,42]; and

c. Effect of Removing Mandatory Minimums and Three Strikes Rules

Whereas, Three-strikes policies and mandatory minimum sentencing deprive judges of the ability to tailor sentencing based on mitigating factors[43-46]; and

Whereas, In 2018, the First Step Act was passed as federal law, lowering mandatory minimums, easing the three-strike rule, and increasing good time credits and earned time credits, but does not impact state-level criminal justice reform, and thus only accounts for 155,741 federal prisoners (as of September 2020) of the total 2.1 million US prisoners in 2020 (only 7.4%)[44-45,47-48]; and

Promoting Rehabilitative Practices in Criminal Justice:

Whereas, According to a survey of violence survivors, victims preferred that the perpetrators of violent crime undergo violence prevention training over incarceration, short sentences and rehabilitation over long sentences, and investment in at-risk youth programs rather than investment in prisons[53]; and

Whereas, Multiples studies, including those focusing on California Proposition 47, the 2007 Crack Cocaine Amendment, and the Fair Sentencing Act, have found that reducing prison sentences does not increase the rate of recidivism[54-56]; and

Whereas, Many countries including Norway, Denmark, and Sweden have significantly shorter prison sentences, and this does not correlate with increased rates of crime[57]; and

Whereas, Our AMA has already recognized the health vulnerability of incarcerated individuals in the US through H-430.979, H-430.985, H-430.986, H-430.987, H-430.988, H-430.989, and H-440.931 which outline measures to address HIV/AIDS, hepatitis C, tuberculosis, COVID-19, substance use disorder, and mental health issues as well as overall poorer health outcomes among incarcerated individuals, demonstrating that AMA recognizes that the effects of incarceration are a threat to public health; and

Whereas, Our AMA has consistently shown support for public health based prevention and rehabilitation strategies, rather than incarceration or criminalization, with numerous policies attesting to the sentiment of prevention and health/social support rather than criminalization, including policies H-95.924 for criminal cannabis use, pregnant mothers who smoke or do drugs, people who exchange sex for money, H-515.958, or do drugs H-100.955; therefore be it

RESOLVED, That our AMA support efforts that reduce the negative health impacts of incarceration by:

(1) advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety rather than retribution,
(2) advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison for minor parole violations or technicalities, and
(3) supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and be it further

RESOLVED, That our AMA works with state medical societies to advocate for legislation that reduces or eliminates mandatory minimums and three-strike rules.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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

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. (Alt. Res. 404, I-20).

H-430.985 Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons
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.
(Res. 404, A-17).

H-430.986 Health Care While Incarcerated
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities. (CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21).

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities

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

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

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

H-430.989 Disease Prevention and Health Promotion in Correctional Institutions
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, and hepatitis. 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. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20).

H-440.931 Update on Tuberculosis
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. (BOT Rep. JJ, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13).

H-60.986 Health Status of Detained and Incarcerated Youth
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. (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).

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

H-80.993 Ending Money Bail to Decrease Burden on Lower Income Communities
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. (Res. 408, A-18).

H-65.952 Racism as a Public Health Threat
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
5. 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.
6. 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.
7. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies. (Res. 5, I-20).

H-65.954 Policing Reform
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. (Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21).

H-95.931AMA Support for Justice Reinvestment Initiatives
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. (Res. 205, A-16).

H-430.981 Preventing Assault and Rape of Inmates by Custodial Staff
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. (CSAPH Rep. 01, A-20).

H-430.998 Use of the Choke and Sleeper Hold in Prisons
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. (Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15).

H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes
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.
6. 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. (Res. 406, A-16; Modified: BOT Rep. 28, A-18).

H-15.964 Police Chases and Chase-Related Injuries
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. (CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13).

H-345.972 Mental Health Crisis Interventions
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. (Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21).

D-160.919 Increased Use of Body-Worn Cameras by Law Enforcement Officers
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. (BOT Rep. 18, A-19).

H-145.977 Use of Conducted Electrical Devices by Law Enforcement Agencies
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. (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14).

H-60.902 School Resource Officer Qualifications and Training
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. (Res. 926, I-19).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 59
(A-23)

Introduced by: Andrew Alexander, Texas A&M College of Medicine; Vishal Reddy, University of Virginia School of Medicine; Sweta Parija, University of California San Diego; Avani Yaganti, Southern Illinois University School of Medicine

Subject: Addressing Misinformation with Augmented Intelligence

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Augmented Intelligence (AI) is a set of computational methods that produce systems that perform tasks normally requiring human intelligence, thereby serving to assist in the work involved with clinical decision-making and related tasks[1]; and

Whereas, Medical misinformation is information contrary to the consensus of the scientific community that may or may not be intended to mislead[2,3,4]; and

Whereas, Medical misinformation is spread by many different sources online, such as online forums, advertisements, user comments on news sites, social media, search engines, digital magazines, and products sold by online retailers[2,4,5,6]; and

Whereas, Medical misinformation has a large impact on a wide variety of healthcare topics including smoking, statin use, use of treatments not supported by research, harassment of health workers, and vaccine hesitancy[6,7]; and

Whereas, A study assessing the propagation of misinformation regarding the Zika virus found that rumors had three times more shares than verified stories[6,8]; and

Whereas, It was found that misinformation propagated significantly farther and faster online than did accurate information, with truthful Twitter posts taking six times longer to reach 1500 people compared to misinformation on the same topic, along with truthful posts taking nearly 19 times longer to be retweeted 10 times than misinformation[6,8,9]; and

Whereas, More than half of the United States population used the internet as their primary source for health information in 2018, indicating a reliance on websites for health information[10]; and

Whereas, Research has shown that exposure to just five online misinformation posts about the COVID-19 vaccine were sufficient to make respondents less likely to want a COVID-19 vaccine[6,11]; and

Whereas, Chatbots are a tool designed to socially interact with other humans and robots through predetermined responses based on analyzing user input and accessing relevant data, and are capable of running on Augmented Intelligence[12,13]; and

Whereas, Previous research has shown COVID-19 related health chatbots are primarily used for disseminating health information and knowledge, and Augmented Intelligence has been used as a valuable tool to power these chatbots[12,13]; and

Whereas, The World Health Organization has already begun using chatbots to prevent the spread of misinformation surrounding COVID-19, indicating that chatbots, with or without Augmented Intelligence, are already being used to combat misinformation and are viewed by major healthcare organizations as being worth their cost[14]; and

Whereas; The State of California has launched a chatbot program aimed at combatting misinformation regarding COVID-19, which has improved access to accurate medical information to Spanish speaking residents, starting over 2000 conversations within 24 hours of its launch[15]; and

Whereas, An AI chatbot focused on COVID-19 vaccine information was trialed by five healthcare systems in Colorado, and achieved a final accuracy rate of 91.1% with only 3994 questions after one year, indicating that chatbots can achieve substantial degrees of accuracy despite being a new field and with a relatively small amount of training data[16]; and

Whereas, The cost of using ChatGPT-3 to train a model fine-tuned for a specific purpose, such as that of healthcare, is roughly $0.000014 per four-sentence paragraph in the training data, indicating that the AI cost component of the chatbot is likely to be manageable[17]; and

Whereas, A preliminary AI chatbot model was able to accurately determine the question being asked more than 85% of the time[16]; and

Whereas, In the event that an AI chatbot model is at risk of misunderstanding a question, the model can opt to instead ask the user to pick from a list of the intentions behind the question that the model has deemed most likely, indicating that failsafes can be implemented to prevent these chatbots from producing inaccurate information in the face of a poorly-worded question[16]; and

Whereas, The accuracy of information provided by the source data used to train an AI chatbot can be controlled by having researchers manually select the healthcare information used to train it, and this information can also be kept up-to-date by utilizing the aforementioned manual selection of information[16]; and

Whereas, Although bots can be used to disseminate accurate information, bots, when used by spreaders of misinformation, simultaneously play a critical role in contributing to the viral spread of misinformation and make up 33% of top sharers of low-credibility content on social media[18]; and

Whereas, Researchers have shown that the use of Augmented Intelligence is effective in detecting misinformation and bots that spread misinformation, indicating a means by which Augmented Intelligence could assist in opposing the spread of misinformation by non-truthful bots[19,20]; and

Whereas, It is possible to create tags such as "verified user" to tell bot detectors on social media that an account is verified to be a human and should be ignored, providing a mechanism that should be easily applicable to truthful AI chatbots to prevent them from being flagged as a misinformation bot when used on social media[21]; and

Whereas, Researchers have shown that using Augmented Intelligence significantly increased readers' ability to identify truth in emerging news sources when compared to looking at news sources alone, indicating a route by which Augmented Intelligence could be used to protect users from false news[19,20]; and

Whereas, The current AMA policies on Augmented Intelligence, H-480.939, H-480.940, and H-295.957, do not have any involvement in addressing misinformation by utilizing Augmented Intelligence, nor do any of its clauses have scope that would cover this; and

Whereas, AMA policy D-440.915 does not cover the use of chatbots to address misinformation in its technology-specific clauses, as it addresses altering moderation of social media websites or altering their code or algorithms, neither of which would encompass the use of chatbots; therefore be it

RESOLVED, That our AMA support research into the use of Augmented Intelligence-powered chatbots to address online medical misinformation; and be it further

RESOLVED, That our AMA supports research into the use of Augmented Intelligence to detect misinformation-spreading bots and general misinformation online.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA:

(1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;
(2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;
(3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
(4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Augmented Intelligence in Medical Education H-295.897
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 60
(A-23)

Introduced by: Andrew Alexander, Texas A&M College of Medicine; Sasidhar Karuparti, University of Missouri School of Medicine; Vishal Reddy, University of Virginia School of Medicine, Siddhant Sharma, University of New England; Siam Muquit, Johns Hopkins School of Medicine

Subject: Addressing Phone and Email Scams Related to Healthcare Insurance

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Health fraud scams are defined by the United States Food and Drug Administration as “products that claim to prevent, treat, or cure diseases or other health conditions, but are not proven safe and effective for those uses,”[1]; and

Whereas, The United States Federal Bureau of Investigation further defines health fraud scams as including false marketing: ”Convincing people to provide their health insurance identification number and other personal information to bill for non-rendered services, steal their identity, or enroll them in a fake benefit plan” and defines impersonating a healthcare professional as: ”Providing or billing for health services or equipment without a license”[2]; and

Whereas, The National Council on Aging lists health-related scams such as Medicare fraud, counterfeit prescription drugs, and fraudulent products in their top ten scams targeting seniors[3]; and

Whereas, Since the COVID-19 pandemic, medical scams, particularly those targeting older individuals to offer fraudulent treatments that decrease the risk of SARS-CoV-2 infection, the frequency of scams has risen[4]; and

Whereas, Phishing attacks, a form of cyber attack where the attacker attempts to lure the user into downloading malicious software or unknowingly disclosing sensitive information, became the most common form of cyber attack since the start of the COVID-19 pandemic[5]; and

Whereas, Successful phishing attacks can be perpetrated through exploitation of emails, websites and mobile devices, allowing attacks to be frequent and widespread[5]; and

Whereas, In 2019, prior to the COVID-19 pandemic, there were 33,739 health care-related fraud reports according to the United States Federal Trade Commission (FTC) Consumer Sentinel Network, and in 2021, during the COVID-19 pandemic, the FTC Consumer Sentinel Network reported 77,483 health care-related fraud events, amounting to $19.2 million dollars in total loss, which does not include events in which criminals impersonate a government entity[6-7]; and

Whereas, From 2014-2022, impersonation of government entities have been one of the leading forms of fraud utilized by criminals in the United States, with 2021 reporting a total of 396,832 reports of government imposter scams, of which the second highest category of scams were criminals impersonating Health and Human Services/Medicare, resulting in $1.37 million in losses to victims[6-14]; and

Whereas, In 2018, the median per-event loss due to Medicare impersonation scams was $489 per event, and in 2022, that number increased to $800[13,14]; and

Whereas, Due to the Families First Coronavirus Response Act and its Medicaid continuous enrollment provision, Medicaid enrollment has increased by 20.2 million since February 2020, and with the unwinding of continuous enrollment, five to fourteen million people will lose Medicaid coverage[15]; and

Whereas, State officials have warned that unwinding of pandemic-era Medicaid coverage will result in those losing coverage becoming vulnerable to scams and misleading marketing, and there is precedent for scams occurring from unwinding of Medicaid coverage[16-17]; and

Whereas, In addition to monetary losses due to errors of fraud susceptibility, consumers can also make errors of undue distrust, resulting in miscommunication between patients and providers, healthcare organizations, and government entities, with the additional potential impacts of physical illness, emotional distress, and increased hospital admissions and mortality[18,19]; and

Whereas, At least one randomized controlled study has demonstrated that training programs ranging from general tips about scams to targeted experiential learning programs successfully and significantly increases fraud detection without decreasing trust in real communications, and another study has found that government social media posts were effective in improving the use of cybersecurity skills by those following the posts, while yet another study indicates that education of potential victims is the best way to prevent a cyberattack[18,20,21]; therefore be it

RESOLVED, That our AMA encourage stakeholders to educate patients on the dangers of healthcare insurance scams and how to report such scams; and be it further

RESOLVED, That our AMA provide educational resources to physicians on the dangers of healthcare insurance scams and how to avoid them, and encourage them to distribute these resources to their patients; and be it further

RESOLVED, That our AMA encourage hospitals to provide information or resources to patients about healthcare insurance scams.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Patient Privacy and Confidentiality H-315.983
Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 61
(A-23)

Introduced by: John Hoverson, James Garcia, Jonathan Dao, Long School of Medicine

Subject: Encouraging Wayfinding Research in Healthcare Facilities

Sponsored by: Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Wayfinding is defined as the "the process of determining a route from one location to another and navigating that route" and is a prerequisite for an individual to successfully accomplish their goals within a building[1]; and

Whereas, An individual's wayfinding ability within a building is significantly impacted by the complexity and layout of the building. As an example, a 2021 study found that buildings with a symmetric tree-branch structure had better wayfinding outcomes that circular structures[2]; and

Whereas, Research has shown that patients' wayfinding abilities in complex healthcare systems can be drastically altered by age, cultural differences, and gender[3,4], and

Whereas, Research on wayfinding in hospitals has found that building complexity and layout play an important role in a patient's perception of the healthcare system which they are utilizing[5]; and

Whereas, Wayfinding research in the context of healthcare settings has indicated that poor hospital design can lead to negative impressions of medical systems and can cause unnecessary emotional stress on both patients and staff[6,7]; and

Whereas, A review article of hospital designs and wayfinding from 2014 found that hospital architects frequently consider wayfinding as an afterthought when designing or re-developing facilities[8]; and

Whereas, Studies into wayfinding have shown that proper wayfinding configurations and techniques within a hospital have positive impacts on patients' abilities to navigate complex healthcare buildings[2,9-11]. As an example, a 2020 study on wayfinding in healthcare settings found that use of tangible servicescape elements, such as appropriately oriented signs, made a significant impact on patient satisfaction[12]; and

Whereas, Two Emergency Department studies found that improved wayfinding design through actions such as eye-level signage, direct public routes, and color-coding systems were linked to better wayfinding and improved staff satisfaction[7,13]; and

Whereas, A 2022 study found that addition of environmental features in hospitals such as more outdoor windows, improved both patient stress levels and wayfinding abilities[14]; and

Whereas, A 2022 from the Czech Republic found the benefits of implementation of a wayfinding system in one hospital outweighed the costs by a factor of five[15]; and

Whereas A 2020 study in the journal of PeriAnesthesia Nursing found that delayed wayfinding contributed significantly to delayed operation start times, but improved when appropriate signage was utilized[16]; and

Whereas, A 2020 review found that decreased patient travel time within a hospital through improvements in wayfinding reduced "idled nursing time, with cost savings accrued to organization", and furthermore showed that "wayfinding mobile applications hold the promise of improving patients' hospital visitation experience."[17]; and

Whereas, Wayfinding has already been recognized by major healthcare organizations as an important aspect of patient satisfaction and has been incorporated as a major area of focus in the Cleveland Clinic's Interior Sign Standards Manual, which creates a clear organizational signage system that is functional, minimal, consistent, and accessible[18]; and

Whereas, The AMA recognizes the importance of ease of access to defibrillators but does not recognize this same importance regarding ease of access to general healthcare resources within hospitals (H-130.938); therefore be it

RESOLVED, That our AMA recognizes the importance of wayfinding research in healthcare buildings as a means to improve patient and staff satisfaction; and be it further

RESOLVED, That our AMA encourages the implementation of wayfinding research in the design of healthcare facilities when possible.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 62
(A-23)

Introduced by: Ellen Hutchinson, Kiana Loo, Carlee Mitchell, Sophia Matts, Trina Pal, Jyothika Yermal, Eija Kent, Hannah Ahrendt, Nikita Das, Chloe Van Dorn, Lorena Wicklund, Lauren Taylor, Sriya Donthi, Andy Mew, Kate Haering, Perrin Fugo, Juliana Sanrame, Allison Epstein, Esha Ghosalkar, Case Western Reserve University School of Medicine; Rommel Morales, Northeast Ohio Medical University; Emily Ridge, Central Michigan University College of Medicine; Alex Grayson, University of Cincinnati College of Medicine; Sarah Khan, Hayley Dunlop, Ohio State University College of Medicine; Jessica M. McAllister, Washington State University Elson S. Floyd College of Medicine; Sarah Costello, University of Iowa Carver College of Medicine

Subject: Comprehensive Reproductive Health Education in the Preclinical Undergraduate Medical Education Curriculum

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Comprehensive reproductive health includes items such as informing and educating individuals on: the provision of family planning services and contraception; the prevention, management, and treatment of sexually transmitted infections; the prevention, management, and treatment of the complications of pregnancy termination; the addressment and treatment of infertility; and the provision of prenatal and postpartum care;[1,2] and

Whereas, Education about comprehensive reproductive health topics, including pregnancy termination, falls within the scope of the Liaison Committee on Medical Education (LCME) Standards 7.2 and 7.5 provisions of classroom and clinical education of organ systems and the addressment of common societal problems, but is not specifically included as a necessary component of the preclinical undergraduate medical education curriculum;[3,4]and

Whereas, The World Health Organization (WHO) and American Academy of Obstetrics and Gynecology (ACOG) include comprehensive reproductive healthcare, including the termination of pregnancy, as essential to protecting the health of women, but the Association of American Medical Colleges (AAMC) Curriculum Reports for Curriculum Topics in Required and Elective Courses at Medical School Programs fail to clearly define comprehensive reproductive health as a subtopic or standalone topic in undergraduate medical education;[3,5] and

Whereas, Research from a 2004 study showed that nearly half of OB-GYN clerkship directors report no formal education on one of the key tenets of comprehensive reproductive healthcare (i.e. termination of pregnancy) in the preclinical years and a follow-up 2020 study showed that 10% report no formal abortion education in preclinical or clinical education, indicating that

preclinical education on comprehensive reproductive health topics during medical school is still inadequate across the country;[6,7] and

Whereas, The vast majority of pregnancy terminations in the United States take place outside of traditional medical student training sites, and opportunities to engage in this form of training may be limited by state-specific legal, societal, and/or institutional barriers, indicating that the curriculum for preclinical undergraduate medical education may be one of the only accessible opportunities for medical students to learn about the diagnosis and management of these pervasive reproductive health topics;[8,9,10] and

Whereas, The health of women and their maternal outcomes is inversely related to abortion restriction laws and this is likely further exacerbated by the shortage of trained abortion providers in the United States, which, in part, is related to stigma, intimidation and shortage-related burnout;[11,12,13,14] and

Whereas, The integration of comprehensive reproductive health topics, including pregnancy termination, into undifferentiated undergraduate medical school curricula has a significant role in addressing the stigma associated with the provision of reproductive health services (i.e. abortion) among medical students and medical professionals, reducing stigma-related complications in abortion care, producing more abortion providers, and preventing abortion-provider burnout;[15,16] and

Whereas, Research surveying medical students has shown a substantial percentage of medical students anticipate providing abortion services in their future practice, desire clinical abortion training during their undergraduate medical education, and believe abortion education is appropriate in the preclinical and clinical curricula;[6,17,18] and

Whereas, Research investigating the utility of preclinical abortion education has shown that after participation in optional educational externships or clinical experiences, students reported more support towards abortion access, being more interested in providing abortion care in their future practice, and feeling more comfortable in abortion counseling;[18,19, 20] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) made a recommendation to "include abortion education in the curricula of all medical schools” and the Association of Professors of Gynecology and Obstetrics (APGO) states, “regardless of personal views about abortion, students should be knowledgeable about its public health importance, techniques, and potential complications”;[11, 21] and

Whereas, Education about comprehensive reproductive health topics, including pregnancy termination, could be integrated into the preclinical medical school curricula by utilizing one of the Instructional Methods Used by Medical Schools reported in the AAMC Curricula Reports, such as case-based instruction, conferences, lectures, patient presentations, and/or simulations, thereby providing opportunities for alternative instruction within abortion-restricted states;[22] and

Whereas, The AAMC Curricula Reports show that from 2011-2014 there has been an increase in the number of medical schools that have simulation centers and the number of medical schools that use simulation as an alternative if students do not have all required encounters; this points to increased flexibility in the way students can be trained, which makes the integration of comprehensive reproductive health education into the preclinical component of the undergraduate medical curriculum more feasible for all medical schools, regardless of abortion care legality;[23] and

Whereas, The AAMC Curricula Reports show that between 2017-2018, 65.3% of medical schools surveyed by the LCME Annual Medical School Questionnaire reported that "a curriculum change is in the planning stage and implementation will begin in the near future" or "curriculum change is in progress", indicating the willingness and ability of medical schools across the U.S. to effectively plan and implement changes in the undergraduate medical education curriculum;[24] and

Whereas, The AAMC Curricula Reports show that the average number of elective weeks required in the preclerkship years has increased to more than 40 in 2021-2022 (versus 20-25 weeks in 2017-2021) with a corresponding increase in the average number of elective weeks available in the 2020-2021 year versus the 2017-2021 years, indicating that there is flexibility for integrating new components into the preclinical component of the undergraduate medical education curriculum;[25] and

Whereas, Our American Medical Association (AMA) policy H-295.923 supports the education of medical trainees about the need for physicians who provide termination of pregnancy services and advocates for access to abortion education and training, but it fails to identify specific action for ensuring access to comprehensive reproductive health education in the preclinical component of the undergraduate medical education curriculum; therefore be it

RESOLVED, That our AMA amends policy H-295.923 Medical Training and Termination of Pregnancy by addition and deletion as follows:

Medical Training and Termination of Pregnancy, H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training~~.~~ by collaborating with relevant stakeholders.

3. Our AMA will collaborate with relevant stakeholders to define comprehensive reproductive health, with explicit mention of termination of pregnancy, and include

comprehensive reproductive health as a required curriculum topic or subtopic in preclinical undergraduate medical education.

4.~~3.~~ In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.

5.~~4.~~ Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

6.~~5~~. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees.

Fiscal Note: Minimal

Date Received: 04/10/2023

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Click here to enter references. References should follow the AMA Reference Citation Format. Sample citations are shown below.

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RELEVANT AMA AND AMA-MSS POLICY

Medical Training and Termination of Pregnancy H-295.923
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.
4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.
5. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees.
Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21; Modified: Res. 317, I-22

Expanding Support for Access to Abortion Care D-5.996
1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care. Res. 229, I-22

Oppose the Criminalization of Self-Managed Abortion H-5.980
Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.
Res. 007, A-18; Modified: Res. 027, A-22

Policy on Abortion H-5.990

The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.
Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22

Amendment to Opinion 4.2.7, Abortion H-140.823
CEJA Opinion 4.2.7, “Abortion,” will be amended as follows:

Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient’s unique values and needs and the physician’s best professional judgment.

The Principles of Medical Ethics of the AMA permit physicians to perform abortions in keeping with good medical practice. CEJA Rep. 1, I-22

Public Funding of Abortion Services H-5.998
The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.
Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CMS Rep. 1, A-15

Right to Privacy in Termination of Pregnancy H-5.993
1. The AMA reaffirms existing policy that:

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

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications. Res. 621, A-22

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.
Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era D-5.998
1. Our AMA Task Force developed under HOD Policy G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted,” will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.
2. Our AMA will work to facilitate support, including legal support through the AMA Litigation Center, as may be appropriate, to physicians that are targeted for practicing in accordance with accepted standards of medical care and medical ethics in the face of legal constraint or any other disciplinary action.
3. Our AMA will advocate for affirmative protections for “conscientious provision” of care in accordance with accepted standards of medical care and medical ethics in hostile environments on par with protection of “conscientious objection." Res. 008, I-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 63
(A-23)

Introduced by: Katie McLaughlin, University of Minnesota Medical School

Subject: Access to Health-Supporting Civil Legal Aid Services as a Social Determinant of Health

Sponsored by: Region 2, Region 4, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A health-harming civil legal need is defined as "a social problem that adversely affects a persons' health or access to healthcare;"[1] and

Whereas, The World Health Organization defines "social determinants of health" (SDOH) as non-medical factors that influence health outcomes;[2] and

Whereas, Health-harming legal needs include but are not limited to access to healthcare, safe housing and work environments, safeguards against financial exploitation, and assistance with family issues such as protection from abusive relationships, child support, and custody;[1] and

Whereas, A health-harming civil legal need is a type of social determinant of health;[1,4] and

Whereas, Civil legal problems related to health affect more than two in five (41%) low-income households;[3] and

Whereas, The average low-income individual deals with two or three health-harming legal needs at a time;[1] and

Whereas, 71% of low-income households experienced at least one civil legal problem in the last year, including problems with health care, housing conditions, disability access, veterans' benefits, and domestic violence;[1] and

Whereas, In 2021, 1 in 2 (55%) low-income Americans who personally experienced a civil legal problem said these problems "substantially impacted their lives," with consequences affecting their finances, mental health, physical health and safety, and relationships;[5] and

Whereas, People of color, women, immigrants, the elderly, people with disabilities, LGBTQ+ people, and people living in rural communities are more likely to live in poverty and more likely to need civil legal services;[6,7] and

Whereas, When civil legal needs are unmet, it is common for health conditions including both physical and mental health conditions to arise or for existing health conditions to be exacerbated;[8] and

Whereas, Substandard housing conditions, eviction, and even the threat of eviction has been connected to anxiety, depression, asthma, bodily injury, and respiratory infection;[4] and

Whereas, Civil legal aid refers to both free legal advocacy and legal information for low- and middle-income people, and includes: direct services by legal aid attorneys and pro bono volunteers, identifying and addressing systemic issues, and self-help and community education;[9] and

Whereas, Access to civil legal aid services is a critical means to target underlying causes and conditions that contribute to poor health;[8] and

Whereas, The high cost of civil legal services poses a significant barrier to access to civil legal services for most low- and moderate-income Americans;[10] and

Whereas, In 2021, low-income Americans did not get any or enough legal help for 92% of the problems that have had a substantial impact on them;[5] and

Whereas, In 2021, low-income Americans reported that they sought seek help for only 1 our of every 4 (25%) civil legal problems that impact them substantially;[5] and

Whereas, Civil legal aid services throughout the country are chronically underfunded, resulting in these entities turning away an average of 50% of eligible individuals who seek their services;[14,15] and

Whereas, Patients who receive civil legal services have improved access to retroactive benefits and debt relief, reduced stress, improvements in asthma control, better use of preventive care for newborns and infants, and decreases in readmission rates, inpatient stays, and emergency department visits;[11] and

Whereas, It has been demonstrated that providing legal services in health care settings, including through medical-legal partnerships, can address unmet legal needs and social factors that contribute to poor health;[1,12] therefore be it

RESOLVED, That our AMA recognize health-promoting civil legal services include but are not limited to legal services that support access to healthcare, safe housing and work environments, safeguards against financial exploitation, and assistance with family issues such as protection from abusive relationships, child support, and custody; and be it further

RESOLVED, That our AMA recognize access to health-promoting civil legal aid services as a social determinant of health.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Legal Protection and Social Services for Commercially Sexually Exploited Youth 60.023MSS
That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (MSS Res 40, A-14) (MSS Res 4, I-14 Adopted as Amended [D- 60.969]) (Reaffirmed: MSS GC Rep A, I-19)

Support for the Establishment of Medical-Legal Partnerships 440.093MSS
Our AMA-MSS supports the expansion and development of medical-legal partnerships to better address social determinants of health. (MSS Res. 040, Nov. 2020)

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants ofhealth in health insurance benefit designs;

3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition ofdata related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (CMS Rep. 7, I-20, Reaffirmed: CMS Rep. 5, I-21, Reaffirmed: CMS Rep. 5, A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 64
(A-23)

Introduced by: Vedika Karandikar, Amanda Kahn, Catriona Hong, Elizabeth Suschana, Leelakrishna Channa, University of Connecticut School of Medicine; Archita Goyal, Tufts University School of Medicine

Subject: Expanding Automated External Defibrillator Placement in K-12 Schools, Health Clubs, and Gym/Recreational Exercise Facilities

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Heart disease is the leading cause of death in the United States[1] and more than 350,000 out-of-hospital cardiac arrests occur in the United States each year[2]; and

Whereas, In the general population, sudden cardiac arrest accounts for 1 in 1,000 deaths[3]; and

Whereas, In young athletes, sudden cardiac death is the leading cause of death, accounting for about 1 in 50,000 to 1 in 80,000 deaths[3]; and

Whereas, Studies show that young individuals with inherited or congenital cardiac disease and adults with occult or diagnosed heart disease have an increased risk of developing cardiovascular events acutely during or shortly after exercise[4,5]; and

Whereas, In young individuals, sudden cardiac arrest can be the first recognized symptom of underlying cardiac pathology[6]; and

Whereas, The proportion of sudden cardiac deaths related to physical exertion is estimated to be as high as 26%, with 61% to 80% of sudden cardiac deaths in athletes occurring during or after physical exertion, especially in those between 10-19 years of age [7,8]; and

Whereas, Research published in the Journal of the American College of Cardiology reports that among sedentary adults, the relative risk of sudden cardiac death was 56 times higher compared to other times and, for those with the highest level of habitual activity, the risk of sudden cardiac death was still 5 times higher during exercise[5]; and

Whereas, The most effective immediate treatment for resuscitation in sudden cardiac arrest for all age groups is cardiopulmonary resuscitation (CPR) with use of an automated external defibrillator (AED)[9]; and

Whereas, A study published in 2020 using the Cardiac Arrest Registry to Enhance Survival (CARES) database found that the use of AEDs on pediatric patients during out-of-hospital cardiac arrests was related to better survival outcomes[10]; and

Whereas, The Journal of the American College of Cardiology reports that in children, the survival rate of a sudden cardiac event is 6.7-10.2%, but in schools with AED programs the survival was ~10x higher (64-72%)[11]; and

Whereas, A 2022 Systematic Review suggests that AED application by lay rescuers is associated with improved survival with a good/moderate cerebral performance category post hospital discharge amongst those between children 1-18 years old[12]; and

Whereas, A Danish study, published in 2022, found the median age for sudden cardiac arrest related to exercise to be 61 years for out of hospital-cardiac-arrest and found that the use of AEDs by bystanders was significantly higher in the group that survived (48.3%) compared to the group that did not (25.4%)[13]; and

Whereas, Cardiac arrest victims who received a shock from an AED administered by a bystander had a 2.62 times higher odds of survival to hospital discharge compared to those who received an AED shock first after the arrival of emergency responders[2]; and

Whereas, Sports-related sudden cardiac arrest is more likely to be a witnessed event, and bystander cardiopulmonary resuscitation and use of cardiac defibrillation are the best independent predictors for survival to hospital discharge[14]; and

Whereas, The AHA recommends that “AEDs should be available to all cardiac arrest victims within 5 minutes, in all settings, including competition, training, and practice[13]; and

Whereas, The American Heart Association (AHA) and other national organizations recommend comprehensive public access to defibrillators, especially in public locations such as schools, fitness centers, and workplaces and recommend the adoption of state legislation to increase access to rescuer PAD programs[14]; and

Whereas, Thirty-eight states passed legislation supporting targeted AED placement[15]; and

Whereas, Thirty-seven of those states required or authorized specific locations, but only 15 required or authorized placement in health, fitness and/or athletic facilities, and only 25 required placement in schools[15]; and

Whereas, The Journal of the American College of Cardiology reports that only 25% of U.S. schools are in states that require installation of AED in any school and nearly 35 million public elementary and secondary students attend schools without a legislative requirement for a school AED[11]; and

Whereas, A Michigan study published in the Journal of Pediatrics found that schools with >20% students from groups of racial minority had significantly less AEDs available compared to schools with more racial diversity[16]; and

Whereas, One study conducted amongst schools in Ohio and Michigan evaluated whether existing AEDs at schools were placed at locations that were accessible, concluding that that even when a staff member jogged to retrieve an AED, up to one third of schools had AED placement with an insufficient radius of care[17]; and

Whereas, The main obstacle for installation of AEDs in schools is the upfront cost, however successful AED treatment reduces long term downstream cost and, additionally, the total cost of

"adding an AED to educational budgets would be a small line item, because of the high total expenditure for education per student in the United States"[11]: and

Whereas, AMA **D-470.992** supports state legislation and/or state educational policies encouraging AED placement in high school and college interscholastic and/or intercollegiate athletic facilities but do not mention elementary or middle schools, locations of collegiate athletic events, or health clubs/fitness and recreational centers; and

Whereas, While existing research supports widespread placement of AED devices,[4,13,14] there is a paucity of research on the prevalence of AEDs at K-12 schools and in recreational exercise facilities as well as of research on the effectiveness of AED placement; therefore be it

RESOLVED, That our AMA amend D-470.992 by addition and deletion to read as follows:

> **Implementation of Automated External Defibrillators in K-12~~High~~ Schools, ~~and~~ College Sports Programs, Health Clubs, and Gym/Recreational Exercise Facilities to be Amended, D-470.992**
> Our AMA supports state legislation and/or state educational policies encouraging: (1) each K-12 ~~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 locations of events; and (2) health clubs and gyms/recreational exercise facilities have automated external defibrillators at all locations; and ~~(2)~~(3) 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; and (4) research efforts will be directed to identify gaps in public AED accessibility to guide optimal placement.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

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.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 65
(A-23)

Introduced by: Ishaan Rischie, Hannah Harrelson, Rachel Rezabek, Aaron D. Smith, Erik-Stephane Stancofski, Caroline Sublett, Shreya Shetty, Shaina Twardus, Brianna Sells Baldwin, Kimberly Duru, University of Virginia School of Medicine; Carson Hartlage, University of Cincinnati College of Medicine; Jara Crawford, Indiana University School of Medicine; Aaron Pathak, Baylor College of Medicine; Holley Carlson-Riddle, Western University of Health Sciences College of Osteopathic Medicine of the Pacific-Northwest; Jessica MacIntyre, University of Connecticut School of Medicine; Clairisse Whang, Rohit Mukherjee, Robert Wood Johnson Medical School

Subject: Addressing the Health Impacts of Discrimination and Rejection on LGBTQ Youth in Foster Care

Sponsored by: Region 1, Region 2, Region 4, Region 5, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Approximately 30% of youth in foster care identify as LGBTQ, which is three times greater than youth not in foster care and is likely a conservative estimate since population-based data on LGBTQ youth in foster care are not formally available[1–4]; and

Whereas, The lack of systematic or routine data collection of sexual orientation and gender identity demographics from foster youth severely limits the system's ability to understand and address the unique challenges facing LGBTQ youth in foster care[5]; and

Whereas, Previous studies demonstrate that LGBTQ youth are not only twice as likely to enter into foster care, but are also more likely to spend longer periods of time in care, to be removed from placements due to frequent hostility based on their sexual orientation or gender identity, and to age out of care without adequate preparation for higher education, employment, and housing in adulthood[6–14]; and

Whereas, In the 2022 National Survey on LGBTQ Youth Mental Health, the Trevor Project found that only 37% of youth identify their home as an LGBTQ-affirming space[15]; and

Whereas, Within the foster care system, LGBTQ youth encounter unique and significant threats to safety due to their sexual orientation or gender identity, including, but not limited to, rejection, harassment, violence, and discrimination from social workers, foster parents, residential staff, and other peers in care[16–24]; and

Whereas, Poor foster care experiences and health outcomes are exacerbated when LGBTQ youth have intersecting minority racial, ethnic, and religious statuses due to heightened

concerns of negative repercussions from child welfare agency staff, foster caregivers, and peers[2,25]; and

Whereas, LGBTQ youth in foster and residential social care experience significantly poorer physical health, mental health, and overall wellbeing outcomes (trauma, substance use, survival sex, and hospitalizations) than their non-LGBTQ counterparts[1,4,5,8,11,26]; and

Whereas, LGBTQ youth in foster care experience lower levels of overall sexual well-being and report higher rates of sexual victimization and unintended pregnancies than heterosexual youth in foster care[27]; and

Whereas, LGBTQ youth in California were twice as likely to receive poor treatment in the foster care system and report higher rates of hospitalization, suicidal ideation, and depression[1,5]; and

Whereas, The Trevor Project found that LGBTQ youth who live in a community that is accepting of LGBTQ people reported significantly lower rates of attempting suicide than those who do not[15]; and

Whereas, Social workers report that they lack adequate knowledge, training, and cultural competence to meet the protective needs of LGBTQ youth in foster care[28]; and

Whereas, Social care professionals at religiously-affiliated residential foster care facilities in the United States were found to be propagating damaging stereotypes about same-sex relationships as pathological, predatory, or circumstantial[29]; and

Whereas, Federal legislation, specifically Title VI of the Civil Rights Act of 1964, does not provide protections against the discrimination of LGBTQ individuals in federally-funded programs, such as federally-funded child welfare agencies for adoption and foster care, and attempts to explicitly provide these nondiscrimination protections, such as the Equality Act and the Every Child Deserves a Family Act, have failed to pass into federal law[30–36]; and

Whereas, The lack of inclusive protections for LGBTQ individuals in federal legislation such as the Civil Rights Act of 1964, the Fair Housing Act, and the Affordable Care Act has enabled numerous rule changes and proposals in recent years that permit discrimination based on sexual orientation and gender identity[37–39]; and

Whereas, In 2020, the United States Children's Bureau eliminated requirements collecting data on sexual orientation and gender identity in the Foster Care Analysis and Reporting System, which further diminished the ability of child welfare agencies to maintain accurate information on LGBTQ youth in foster care, thus hindering their ability to develop programs, obtain funding, and improve laws protecting LGBTQ foster youth[40–42]; and

Whereas, Only thirteen states and the District of Columbia have specific laws and policies in place to protect LGBTQ foster youth from discrimination based on both sexual orientation and

gender identity, and twelve other states only include sexual orientation, but not gender identity, as a protected class in child welfare regulations[7,43,47]; and

Whereas, Of the fifteen states that have enacted a Foster Children's Bill of Rights, only nine states explicitly provide foster youth with rights to access health services, and only three states – California, Hawaii, and Massachusetts – include rights to nondiscrimination on the basis of gender identity and sexual orientation[44,47]; and

Whereas, According to the United States Government Accountability Office, some states such as Georgia have no protections based on sexual orientation or gender identity for foster youth or prospective foster parents in state law, regulation, policy, or agency practices[45]; and

Whereas, Only California, Florida, Louisiana, and Texas had regulatory guidance regarding placement of transgender youth in out-of-home care in alignment with gender identity as of 2016, and child welfare agency officials from Kansas, Ohio, and Mississippi reported placing transgender youth in gender-segregated residential facilities by their sex assigned at birth rather than their gender identity[45,46]; and

Whereas, As of 2021, New Jersey child welfare agency officials reported successfully recruiting and licensing at least 120 new foster homes that would be affirming and supportive of LGBTQ youth through local LGBTQ community organization, home studies, or training sessions[45]; and

Whereas, Organizations such as the Children's Bureau and Child Welfare League of America provide fact sheets and brochures with passive guidance on supporting LGBTQ youth in foster care[47–52]; and

Whereas, Established programs such as *RISE, Reaching Higher*, and the *Family Acceptance Project* partner with youth, caregivers, or professionals (social workers, clergy, etc.) to provide more effective training and personalized guidance on physical, emotional, medical, and community support for LGBTQ youth in foster care[7,12,48–50,53–56]; and

Whereas, Implementation of the *RISE Care Coordination Team Program* was shown to have helped LGBTQ youth in the Los Angeles foster care system keep and increase connections with adults, feel increased support of their sexual orientation or gender identity, and help them to discuss and disclose their sexual orientation or gender identity[53]; and

Whereas, Even though AMA policies H-60.910 and H-160.991 separately address the healthcare needs of youth in foster care and of LGBTQ individuals, the AMA has only written one letter of correspondence to the United States Department of Housing and Urban Development in opposition to a proposed rule change that removes non-discrimination protections for making placement determinations on the basis of gender identity in sex-specific housing facilities and shelters[57]; and

Whereas, AMA-MSS policy 65.002 demonstrates ongoing AMA-MSS support for the implementation of nondiscrimination policies in order to protect the rights of persons who suffer from prejudice, such as the uniquely marginalized and underserved population of LGBTQ youth in foster care; therefore be it

RESOLVED, That our AMA recognizes that LGBTQ youth are disproportionately represented in foster care systems where they are vulnerable to unique forms of maltreatment that both cause and exacerbate disparities in physical health, mental health, and overall well-being outcomes; and be it further

RESOLVED, That our AMA supports federal and state legislation that establishes nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity; and be it further

RESOLVED, That our AMA supports efforts by the Department of Health and Human Services and other appropriate stakeholders to establish reporting requirements and necessary privacy protections for the collection of sexual orientation and gender identity data in the Foster Care Analysis and Reporting System; and be it further

RESOLVED, That our AMA encourages child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ youth; (b) adopt programs to prevent and reduce violence against LGBTQ youth in foster care; (c) improve recruitment and tracking of foster families that are affirming of LGBTQ youth; and (d) allow gender diverse youth to be placed in residential foster homes that best align with their gender identity.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS 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.
(Res. 907, I-17)

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

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

Family Violence-Adolescents as Victims and Perpetrators, H-515.981
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 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.
(CSA Rep. I, A-92) (Reaffirmed: CSA Rep. 8, A-03) (Modified: CSAPH Rep. 1, A-13)

Preventing Anti-Transgender Violence, H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
(Res. 008, A-19)

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations, H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
(Res. 402, A-12) (Reaffirmed: CSAPH Rep. 1, 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.
(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)

Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care, D-350.977
Our AMA:
(1) recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation;

(2) supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause;
(3) will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause;
(4) supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems;
(5) will support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals.
(6) will advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care.
(7) will advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry.
(8) will promote existing medical homes which provide continuity of care to children in foster care when feasible.
(9) will support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency.
(Res. 443, A-22) (Appended: Res. 930, I-22)

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.
(CSA Rep. 7, I-00) (Reaffirmed: CSAPH Rep. 2, I-09) (Modified: CSAPH Rep. 01, A-19)

Nondiscrimination Based on Sexual Orientation, 65.002MSS
AMA-MSS continues to support its positions that nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice.
(AMA Res 12, A-89 Adopted [H-295.969]) (Reaffirmed: MSS Rep D, I-99) (Modified: MSS GC Rep A, I-16)

Addressing Foster Care Healthcare Needs, 440.062MSS
AMA-MSS will ask that our AMA advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children.
(MSS Res 17, A-17)

Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System, 60.037MSS
Our AMA will amend policy H-60.910, by addition and deletion to read as follows:

ADDRESSING HEALTHCARE NEEDS OF <u>YOUTH</u> ~~CHILDREN~~ IN FOSTER CARE, H-60.910

<u>1.</u> Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ <u>youth</u> in foster care

<u>2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age.</u>

(MSS Res. 097, Nov. 2020)

Reducing Suicide Risk among LGBTQ+ Youth through Collaboration with Allied Organizations, 65.015MSS
AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce LGBTQ+ youth suicide and improve health among LGBTQ+ youth.
(MSS Res 24, A-11) (AMA Res 402, A-12 Adopted [H-60.927]) (Reaffirmed: MSS GC Report A, I-16) (Amended: LGBTQ+ Report A, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 66
(A-23)

Introduced by: Ashwin Varma, University of Texas Health Science Center at San Antonio Long School of Medicine; Samantha Pavlock, Florida State University College of Medicine

Subject: Supporting Policies which Increase Biosimilar Penetration

Sponsored by: Region 2

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Although biologics drugs only account for 2% of pharmaceutical prescriptions by volume, they currently account for ~37-43% of U.S. pharmaceutical spending and have accounted for ~90% of the net pharmaceutical spending growth over the past decade[1-6]; and

Whereas, On average, biologic medications are significantly more expensive than small molecule drugs, as prices average ~$10,000-$40,000 per patient per year, with prices often ranging to $500,000[1-6]; and

Whereas, Biosimilar medications are defined by the Food and Drug Administration (FDA) and European Medicines Agency (EMA) as biological drugs (usually recombinant proteins or monoclonal antibodies) which are highly similar to and have no clinically meaningful differences in terms of safety, purity, and potency when compared to another already approved biological medicine (often referred to as the 'reference product')[7]; and

Whereas, under the 2010 Biologics and Price Competition Act, the Food and Drug Administration currently has created and operated a licensure pathway (called the 351(k) pathway) for approving biosimilars of originator biologics and since 2018 has also standardized its requirements for approving “interchangeable biologics”, which are a subset of biosimilar drugs which can be substituted at the pharmacy-level without physician intervention (and are approved via the 351(k)(4) pathway)[7-8];

Whereas, While biosimilar approval and uptake has markedly improved in the U.S. since 2015, biosimilar penetration in the U.S. is still considerably poorer than seen Organisation for Economic Co-operation and Development (OECD) countries; the U.S. market supports ~50% of the number of approved biosimilars and demonstrates an average penetration rate of ~20% as compared to 80+% in Europe[9-17].

Whereas, In addition to poorer rates of biosimilar approval and uptake, the realized price savings from biosimilars have also lagged those seen in Europe; the average price declines in the U.S. range from 15-40% while price declines in Europe can range up to 70%, more closely approximating the declines in prices seen with small molecule generics[9-17]; and

Whereas, "Interchangeable" biosimilars are defined by the Food and Drug Administration (FDA) as biosimilar products which can be "substituted for the reference product without the intervention of the health care provider who prescribed the reference product"[7]; and

Whereas, Interchangeable biologics have been associated with a higher magnitude of both penetration and price declines when compared to non-interchangeable biologics[18-24]; and

Whereas, The U.S. regulatory requirements to designate a biosimilar as 'interchangeable' under the 351(k)(4) pathway are significantly more stringent than in Europe; to demonstrate 'interchangeability' the FDA still requires that sponsors conduct a Phase 3 switching non-inferiority trial (in which patients are switched between the biosimilar and reference agent repeatedly in a clinical trial setting) whereas the EMA considers all biosimilars as 'interchangeable' without the need for an additional switching study[18-24]; and

Whereas, The larger barriers to achieving an "interchangeable" designation in the U.S. provide one reason that uptake of biosimilar has been lower in the U.S. than in other OECD countries[18-24]; and

Whereas, Despite concern that biosimilars which do not undergo switching studies might have unknowable differences in clinical efficacy or safety in patients, long-term follow-up of biosimilars in countries lacking a similar-interchangeable distinction have not demonstrated any notable difference in the safety of biosimilar products relative to originators, questioning the need for switching studies in designating biologics as 'interchangeable'[23-24]; and

Whereas, European health systems have also improved biosimilar uptake through a variety of economic mechanisms which make financially lucrative for physicians, including via rewards for biosimilar usage targets (in which physicians who hit XX+% of biosimilar prescription for new patients are granted a fixed reward) or via shared savings (in which physicians are able to share in the savings they generate for the health system by prescribing lower cost drugs)[24-30]; and

Whereas, Usage targeting and shared savings should be differentiated from "internal reference pricing", in which a group of biosimilar products are reimbursed at a flat rate to encourage physicians to prescribe the lowest priced biosimilar product available, which is the subject of a pending MSS transmittal[31]; and

Whereas, One strategy leveraged by biologics originators to stem market share losses to biosimilars involves signing long-term exclusivity clauses with Pharmacy Benefit Managers (PBMs), trading short-term savings for long-term reductions in biosimilar entry; for example Pfizer sued Johnson & Johnson for allegedly leveraging exclusive distribution clauses with PBMs to protect Remicade market share [32-33]; and

Whereas, Exclusive distribution clauses are a type of business practice which the Federal Trade Commission (FTC) and Department of Justice (DOJ) have the authority to investigate and block under Section 2 of the Sherman Antitrust Act[34-35]; and

Whereas, Though the FTC and DOJ have the authority to challenge exclusive distribution clauses, such clauses are subject to the rule of reason, meaning that these clauses are not automatically illegal and thus require specific economic case to be brought by a plaintiff who is aware of the presence of such contracts in the market[34-35]; and

Whereas, The FTC has initiated a study of the competitiveness of the insurance and pharmaceutical benefit manager (PBM) industry, providing an opportunity for the AMA to advocate for study of exclusive distribution clauses as part of this study[36]; therefore be it

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to implement systems for economically encouraging the uptake of biosimilars by physicians, including but not limited to setting rewards for volume targets and via shared savings programs; and be it further

RESOLVED, That our AMA encourage the Food and Drug Administration (FDA) to consider modifying its guidelines for the biosimilar 'interchangeability' designation; and be it further

RESOLVED, That our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Cuts in Medicare Outpatient Infusion Services D-330.960
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Medicare Part B Competitive Acquisition Program (CAP) H-110.983

Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;

(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

180.022MSS Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use

AMA-MSS will ask that our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation. (MSS Res. 033, A-22)

Abbreviated Pathway for Biosimilar Approval H-125.980

Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 67
(A-23)

Introduced by: Wyatt Lanik, Nicholas Bohannon, Quinn Nelson, University of Nebraska College of Medicine; Rushmin Khazanchi, Northwestern University Feinberg School of Medicine; Samantha Barr, University of Wisconsin School of Medicine and Public Health; Adrina Kocharian, University of Minnesota Medical School; Chandana Kulkarni, Burnett School of Medicine at Texas Christian University; Samantha Pavlock, Florida State University College of Medicine; Udit Vyas, Indiana University School of Medicine; Matthew Linz, Rutgers New Jersey Medical School; Kaye Dandrea, University of New England College of Osteopathic Medicine

Subject: Generative Augmented Intelligence as a Threat to Scientific Publications

Sponsored by: Region 2, Region 4, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Generative augmented intelligence (AI) is a category of AI algorithms that uses natural language processing (NLP) and large language models (LLMs) to generate human-like text, audio, and images based on previous training with massive datasets[1-4]; and

Whereas, Generative AI is a deep learning-based network leading to an interactive feedback learning process between two system networks that provide predications to outcomes of interest, such as human-like text[2,3]; and

Whereas, The generative AI model 'ChatGPT' is a model trained using Reinforcement Learning from Human Feedback (RLHF), a framework where human AI trainers rank outputs from AI chat transcripts based on the most desirable behavior[2-4]; and

Whereas, Generative AI has already been used to write essays, summarize scientific literature, develop methods for experiments, interpret raw data, draft an entire research article, and write abstracts, all of which can be difficult to distinguish from human work[5-9]; and

Whereas, Generative AI, specifically ChatGPT, has been used to generate text within a manuscript, and has been listed as a co-author in several recent scientific publications[7-11]; and

Whereas, Increasing amounts of AI-generated publications and discussion pieces on the ethics of AI in science have been published on PubMed and other scholarly databases[12-14]; and

Whereas, Publishers of major research journals including *Springer Nature*, *Science*, and *Elsevier* have issued warnings over concerns of fraud, lack of credibility, and the potential to flood scientific literature with incomplete, AI-generated publications and reviews[15-17]; and

Whereas, Generative AI has been observed to incorrectly reference articles, known as "AI hallucinations," where sources produced by the AI cite the wrong authors or a non-existent, fabricated source[6,11,18,19]; and

Whereas, Generative AI, in its current form, lacks the critical analytic ability of the human mind, making it susceptible to reproducing biases and inaccurate data[11,20]; and

Whereas, Generative AI is programmed to reformulate sentences; however, rephrasing without the direct addition of original thoughts or ideas is plagiarism and therefore should not be an acceptable contribution to academic literature[6,11]; and

Whereas, *Springer Nature* and other scientific journals have published expectations regarding AI usage in its publications including: i) no LLM can be listed as an author in a manuscript; ii) no LLM can be utilized within a publication without explicit detail of its use in a methods section or equivalent; iii) human authors of a manuscript are responsible for the contributions of an LLM to their work and attribution of all sources[15,21,22]; and

Whereas, Scientific publishers are seeking tools to identify LLM use in scientific publications as current AI detection technology has limited success detecting AI-written language, has significant false positive results for human-generated text, and is an area of active research[15,23,24]; and

Whereas, Current AMA policy H-460.972 "Fraud and Misrepresentation in Science" discusses fraud broadly and supports scientific inquiry through specific standardized guidelines for primary research data; however, this policy fails to mention how research data is developed into a written form for human consumption or how primary data and sources are collated into secondary references in scientific literature, which generative AI can accomplish with minimal human supervision; and

Whereas, Current AMA policy H-480.939 "Augmented Intelligence in Health Care" does not address AI utilization in scientific or medical research and its writing, but instead focuses solely on the usage of AI in direct patient care settings or other clinical health care applications; and Sources from the past five years are more persuasive than outdated sources[5]; and

Whereas, Current AMA policy H-295.857 "Augmented Intelligence in Medical Education" is narrow and specifically addresses AI use only as it relates to medical education; therefore be it

RESOLVED, That our AMA support publishing groups and scientific journals in their regulation of generative augmented intelligence written contributions to publications; and be it further

RESOLVED, That our AMA work with relevant stakeholders to raise awareness of concerns about augmented intelligence utilization in research institutions without adequate human supervision and diligence; and be it further

RESOLVED, That our AMA amend by addition H-460.972, "Fraud and Misrepresentation in Science", to read as follows:

Fraud and Misrepresentation in Science H-460.972

The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, generative augmented intelligence in research and scientific publications, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Fraud and Misrepresentation in Science H-460.972
The AMA:

(1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs;
(2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior;
(3) supports the promotion of discussions on the peer review process and the role of the physician investigator;
(4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct;
(5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and
(6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.
(CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11; Reaffirmed: CEJA Rep. 1, A-21).

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to: 1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI. 2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI. AMA-MSS Digest of Policy Actions/ 369 3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information. 4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI. 5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (BOT Rep. 41, A-18).

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities

and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
(BOT Rep. 21, A-19Reaffirmation: A-22).

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

Machine Intelligence in Healthcare 485.003MSS
AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision-making, including diagnosis, patient care, and health systems management;(3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) supports increased utilization of the term "machine intelligence" rather than the term “artificial intelligence” when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making. (MSS Res 37-I-17) (Reaffirmed: MSS Res 22, A-19).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 68
(A-23)

Introduced by: Samantha Pavlock, Florida State University College of Medicine; Gino Dettorre, Washington University School of Medicine in St. Louis; Nicholas Bohannon, University of Nebraska College of Medicine; Matthew Linz, Rutgers New Jersey Medical School; Jacob Beiriger, Sidney Kimmel Medical College; Udit Vyas, Indiana University School of Medicine; Dhruv Puri, University of California San Diego School of Medicine; Ashley Glass, Kansas City University College of Osteopathic Medicine; Justin Magrath, Tulane University School of Medicine; Kiersten Woodyard De Brito, University of Cincinnati School of Medicine; Catriona Hong, Thea Anderson, University of Connecticut School of Medicine; Nikhil Linaval, Keck School of Medicine of the University of Southern California; Shaminy Manoranjithan, University of Missouri School of Medicine, Chandana Kulkarni, Burnett School of Medicine at Texas Christian University; Tanvi Karmarkar, University of Missouri-Kansas City School of Medicine; Kiersten Walsworth, Aila Rahman, Maria Tjilos, Wayne State University School of Medicine; Caleigh Hitchcock, Northeast Ohio Medical University College of Medicine; Ana Untaroiu, Medical College of Wisconsin; Sanchayana Raghuvir, Texas Tech University Paul L. Foster School of Medicine El Paso; Syeda Akila Ally, University of Illinois College of Medicine; Abhishek Dharan, Paul L. Foster School of Medicine at Texas Tech University Health Sciences Center El Paso

Subject: Improving Hazardous Chemical Transport Regulations for Public Health Protections

Sponsored by: Region 2, Region 3, Region 5, Region 6

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Hazardous materials are defined as a substance or material that the Secretary of Transportation has determined is capable of posing an unreasonable risk to health, safety, and property[1]; and

Whereas, According to the American Association of Railroads, railroads transport more than 2 million loads of hazardous materials annually[2]; and

Whereas, Within the last 30 years, there have been multiple catastrophic train derailments involving hazardous chemicals (2023, East Palestine, Ohio[3]; 2020, Seattle, WA[4]; 2015, Maryville, TN[5]; 2012, Paulsboro, NH[6]; 2005, Graniteville, SC[7]; 2002, Minot, ND[8]; 1992, MN and WI Border[9]; 1991, Dunsmuir, CA[10]) that resulted in casualties, evacuation of surrounding towns, displacement of residents, significant environmental pollution, and chemical exposures resulting in long-term health complications for affected individuals[3-10]; and

Whereas, The chemicals spilled by railway derailments in states including Tennessee, New Jersey, South Carolina, and California exposed surrounding communities to hazardous

chemicals including acrylonitrile, vinyl chloride, chlorine, and herbicides, leading to chronic medical issues such as increased blood pressure, lung damage, increased rates of post-traumatic stress disorder, and increased risk for liver angiosarcoma[5-7, 10]; and

Whereas, Long-term exposure to benzene, ethylhexyl acrylate, and vinyl chloride have been associated with multiple malignancies including acute myeloid leukemia and hepatocellular carcinoma[11-13]; and

Whereas, Exposure to hazardous chemicals commonly results in hospitalizations for symptoms including but not limited to respiratory issues, skin irritation, burning of the eyes, nausea, vomiting, diarrhea, headache, drowsiness, and dizziness[5-7, 10]; and

Whereas, Railroads are regulated by the Department of Transportation's (DOT) Federal Railroad Administration (FRA) and the Surface Transportation Board[14-16]; and

Whereas, The regulation of hazardous material transport across all modalities is governed by Title 49 Sections 5101-5128 of the U.S. Code of Federal Regulations[17]; and

Whereas, About one-fifth of all inspections by the DOT of commercial vehicles (railroad, highway, and waterway) resulted in a vehicle being placed out-of-service (OOS) for a serious violation such as operating under hazardous conditions or lacking required operating authority[18]; and

Whereas, Current regulations under DOT-117 and DOT-117R require tank cars to have thermal protection barriers for rail transportation of Class 3 flammable liquids, but as of 2021, only 56.8 percent of the 103,312 tank cars used to carry these liquids met these safety requirements[18]; and

Whereas, Hazardous Material Regulation (HMR); 49 CFR parts 171-180 require that hazardous chemical transport be accompanied both by detailed shipping papers that are available to both the transport workers and emergency responders detailing the hazards of that shipment, as well as an emergency response telephone number that can be accessed for immediate use by emergency services[1]; and

Whereas, As of March 1, 2023, the FRA announced a safety initiative for the transportation of hazardous waste, inspecting routes of hazardous waste transport and evaluating electronically controlled pneumatic (ECP) break regulations[19]; and

Whereas, Recently, in February 2023, a railway derailment in East Palestine, Ohio, led to combustion of hazardous material containers, including chemicals such as isobutylene, butyl acrylate, benzene, ethylhexyl acrylate, ethylene glycol monobutyl ether, and 115,580 gallons of vinyl chloride[20]; and

Whereas, After hazardous chemical spillage, despite the Environmental Protection Agency sampling the area's water, air, and soil for contamination, detectable levels of hazardous material remain, causing concern for long-term health consequences from exposure to said chemicals[21]; and

Whereas, Public Health Registries have served as a quick and effective tool to help communities learn about exposures where consequences are unclear[22-23]; and

Whereas, The World Trade Center (WTC) Health Registry involved a collaborative effort between various local and government health agencies to voluntarily enroll people most directly exposed to environmental effects, identify and track the long-term physical and mental health effects of the WTC attack, disseminate findings and recommendations, and develop disaster preparedness and public policy for use in the event of future disasters[24-26]; and

Whereas, The WTC Health Registry helped develop our understanding of the medical consequences of exposure to toxic smoke, dust, and debris and contributed to the creation of the James Zadroga 9/11 Health and Compensation Act of 2010, which offers screenings, medical monitoring and treatment of WTC-related conditions for emergency responders and survivors within the disaster area[24-26]; and

Whereas, Other public health registries, including the Texas Flood Registry, have utilized the successful model of the WTC Health Registry to collect exposure data through collaboration between local health departments, academia, and community stakeholders to identify key areas for environmental health research[24-27]; and

Whereas, Norfolk Southern and other rail companies have successfully lobbied to limit safety regulations and the scope of railroad transportation safety legislation[28-29]; and

Whereas, AMA-MSS policy advocates for reducing harm and minimizing potential adverse events of hazardous chemicals (H-135.942) and recognizes and opposes health risks of hazardous chemical landfills in lieu of aquifers (H-135.943); and

Whereas, AMA policy advocates for chemical manufacturers to provide safety information and gives federal agencies regulatory authority over hazardous chemicals (D-135.976); and

Whereas, The AMA monitors repercussions of health emergencies, for instance the Gulf oil spill, but other health emergencies lack registry or documentation (D-135.980); and

Whereas, AMA policy calls for the development of adequate transportation systems and monitoring of the transportation and storage of hazardous materials (H-135.993) but does not address root complications of transportation and storage of hazardous materials; therefore be it

RESOLVED, That our AMA supports the implementation of a registry system for hazardous chemical transportation across all modalities with this system being made accessible to emergency responders as a means to protect public health; and be it further

RESOLVED, That our AMA amend H-135.993 by addition to read as follows:

> **H-135.993 Transportation and Storage of Hazardous Materials**
> Our AMA <u>(1)</u> requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials, <u>and (2) advocates for the re-evaluation of transport regulations of hazardous chemicals to prevent public health emergencies</u>; and be it further

RESOLVED, That our AMA supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution in its entirety to the 2023 Annual Meeting of the AMA House of Delegates.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-135.942 Modern Chemicals Policies
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.
(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).

H-135.943 Expansion of Hazardous Waste Landfills Over Aquifers
Our AMA:
1. recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
2. will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and
3. supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

(CSAPH Rep. 4, A-07; Reaffirmed: CSAPH Rep. 01, A-17).

D-135.976 Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976
Our AMA will: (1) collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).
(Res. 515, A-12; Modified: Res. 907, I-13; Reaffirmation I-13; Reaffirmation I-16).

D-135.980 Gulf Oil Spill Health Risks and Effects
Our AMA 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).

D-135.987 Modern Chemicals Policies
Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical

students, physicians, and other health professionals about the human health effects of toxic chemical exposures. (Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmation I-16).

H-135.993 Transportation and Storage of Hazardous Materials
Our AMA requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials.
(Sub. Res. 42, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20).

D-440.925 Adverse Impacts of Delaying the Implementation of Public Health Regulations
Our AMA will monitor and evaluate regulation delays that impact public health, and advocate as appropriate to decrease regulatory delays. (Res. 529, A-19).

135.021MSS Environmental Contributors to Disease and Advocating for Environmental Justice
AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows: Research into the Environmental Contributors to Disease and Advocating for Environmental Justice Our AMA will (1) advocate for the 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 and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. (MSS Res. 019, A-21).

440.081MSS Adverse Impacts of Delaying the Implementation of Public Health Regulations
AMA-MSS will ask AMA to 1) examine the feasibility of filing an amicus brief highlighting the detrimental health effects of municipal solid waste landfill pollution in Court Case #18-cv-03237 (State of California et. Al v EPA et. Al); 2) amend H-135.950 Support the Health-Based Provisions of the Clean Air Act to Read as follows: Support the Health-Based Provisions of the Clean Air Act, H-135.950 Our AMA (1) opposes changes to the New Source Review Program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; (3) opposes further legislation, rules, and regulations that weakens the existing provisions of the Clean Air Act; and (4) *support updates to the Risk Management Program such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public*; AMA-MSS Digest of Policy Actions/ 241 3) recognize the significant health risks associated with pesticide exposure; 4) urge the EPA and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children; and 5) analyze ongoing regulation delays that impact public health, as deemed appropriate. (MSS CGPH Rep A, I-18) (AMA Res 529, Adopted as Amended [D-440.925]).

Table of Contents

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 69
(A-23)

Introduced by: Jared Buteau, Trip Crowley, Haley Wymbs, University of South Carolina School of Medicine Greenville; Syeda Akila Ally, University of Illinois College of Medicine Chicago; Renato Guerrieri, McGovern Medical School at UTHealth Houston; Emily Ridge, Central Michigan University College of Medicine; Aarti Patel, Wayne State University School of Medicine; Carson Hartlage, University of Cincinnati College of Medicine; Siena Cooper, Indiana University School of Medicine

Subject: Addressing Barriers to Medication for Addiction Treatment Prescription and Access Following the Drug Addiction Treatment Act-Waiver Removal

Sponsored by: Region 4, Region 5, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Among people aged 12 or older, 3.3% (9.2 million people) misused opioids (heroin or prescription pain relievers) in 2021[1]; and

Whereas, Among the 5.5 million (2%) people aged 12 and older who were diagnosed with a substance use disorder (SUD) involving opioid use, only 21.6% (1.2 million) received any treatment for opioid use disorder (OUD)[2]; and

Whereas, Many barriers to OUD treatment exist including but not limited to: cost of OUD treatment, opportunity cost with regards to methadone treatment appointments, Medicaid quantity and coverage limits, barriers to telehealth prescription, racial disparities in buprenorphine provision, and treatment facility locations[3,4]; and

Whereas, Disparities in access to medication for addiction treatment (MAT) for OUD disproportionately impact historically minoritized racial and ethnic groups (Hispanic, Black), persons of lower socioeconomic status and persons who are uninsured[5-8]; and

Whereas, Under the Drug Addiction Treatment Act of 2000 (DATA), medical practitioners were required to obtain a DATA-waiver via completion of specialized training requirements and submission of a Notice of Intent (NOI) to the DEA in order to prescribe buprenorphine as MAT for OUD[9,10]; and

Whereas, The Consolidated Appropriations Act of 2023 has removed the DATA-Waiver requirement for treating patients with OUD, allowing practitioners with a current DEA registration that includes Schedule III authority to prescribe buprenorphine for OUD without submitting an NOI[10,11]; and

Whereas, Research in 2019 and in 2020 found that increasing the number of providers who could prescribe MAT did not significantly impact prescribing volume[12,13]; and

Whereas, The American Medical Association (AMA) acknowledges that under the DATA-waiver, only a small percentage of practitioners who met requirements to prescribe MAT for OUD actually did prescribe MAT for OUD[14,15]; and

Whereas, The AMA has acknowledged that stigma surrounding prescription of MAT for OUD, as well as fear of litigation discouraged many physicians from pursuing the DATA-waiver, but research has not yet been acquired in light of the DATA-waiver removal[14]; and

Whereas, AMA policy does not currently address newfound barriers to MAT access beyond that of the DATA-waiver requirement; and

Whereas, The AMA and AMA Medical Student Section (AMA-MSS) have already shown their commitment to expanding MAT access and prescription and support for equitable access to OUD treatment under D-95.968, D-95.972, H-120.960, and 95.020MSS; therefore be it

RESOLVED, That our AMA support research involving both socioeconomic and provider-based barriers to implementation of medication for addiction treatment (MAT) for opioid use disorder (OUD) in light of removal of the Drug Addiction Treatment Act-waiver requirement.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
Res 506, A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation. Res. 222, A-18; Appended: BOT Rep. 02, I-19

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.

2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.

Protection for Physicians Who Prescribe Pain Medication H-120.960
Our AMA supports the following:
(1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.

Support Harm Reduction Efforts through Decriminalization of Possession on Non-Prescribed Buprenorphine 95.020MSS

AMA-MSS will ask the AMA to (1) advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and (2) support any efforts to decriminalize the possession of non-prescribed buprenorphine. MSS Res. 017, A-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 70
(A-23)

Introduced by: Ida Vaziri, Emily Liu, UT Health San Antonio Long School of Medicine; Kiersten Walsworth, Aarti Patel, Wayne State University School of Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine; Yuan Xie, Kansas City University College of Osteopathic Medicine; Shaminy Manoranjithan, University of Missouri Columbia School of Medicine

Subject: Protecting the Health of Incarcerated Individuals by Opposing for-profit Prisons

Sponsored by: Region 3, Region 5, Region 6, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A for-profit, or private, prison is a facility where individuals are imprisoned by a private, third-party company that is contracted by a government agency[1]; and

Whereas, A public prison, or government-owned prison, is a public facility where individuals are imprisoned directly by a government agency[1]; and

Whereas, The United States has the highest per capita incarceration rate in the world and the world's largest private prison population, totaling 99,754 people and accounting for 8% of the total prison population in 2020[2]; and

Whereas, The federal government and 26 states currently utilize private prisons, and the number of people incarcerated in these facilities increased somewhere between five to ten times faster than the general prison population from 2000 to 2016[2,3]; and

Whereas, Government contracts that finance for-profit prisons are typically based on total inmate population and average time served in the facility, which leads to a financial conflict of interest, as increased inmate populations and sentencing results in more funds for the facility[1,4]; and

Whereas, For-profit prison corporations reported revenues of nearly $4 billion from government contracts and nearly $3 billion from the sales of goods or services to private correctional facilities, but were estimated to spend less than less than 10% of that funding on healthcare expenditures for incarcerated people[5]; and

Whereas, Public prisons generally spend around 15% of their funds on healthcare for their inmate population, despite having about $2 billion in total funds for the fiscal year, a quarter of what for-profit prisons are given[6]; and

Whereas, For-profit prisons decrease their costs and increase profit by cutting spending on staffing and training, which contributes to a decline in safety and quality for life for incarcerated individuals[3,7]; and

Whereas, Low pay rates in for-profit prisons lead to frequent employee turnover, and a lack of experienced officers directly impacts the quality of life for individuals who are incarcerated[8]; and

Whereas, For-profit prisons were reported to have higher rates of assaults, use of force, lockdowns, contraband finds, rates of inmate isolation, and violation of due process compared to Federal Bureau of Prisons facilities[9-11]; and

Whereas, People incarcerated in for-profit prisons are at a higher risk for inadequate healthcare, and subject to overcrowding, understaffing, and prison riot related injuries[11]; and

Whereas, Reported instances of inadequate healthcare in for-profit prisons include delays in treatment of severely ill inmates, relegation of prisoners requiring medical attention to low-level medical workers, and reluctance to transfer those requiring hospital-level care in attempts to mitigate costs[11]; and

Whereas, For-profit prisons offer fewer substance dependency, psychological/psychiatric, and HIV/AIDS-related programs in comparison to their public counterparts and may be incentivized to reduce healthcare services in order to maximize profit[12]; and

Whereas, Public prisons are funded by tax dollars, therefore they are obligated to provide data about the operations of the prison facility, such as general operations, prisoner health care, parole/probation services, administrative support, and community programs, to the public so that the public can provide community feedback in return[1,6]; and

Whereas, In contrast to private prisons, public prisons are required to publish this data, meaning that they can be held accountable for violations of adequate health care, human rights, and dignity[13]; and

Whereas, The inaccessibility of data regarding the treatment and rehabilitation of prisoners in for-profit prisons also hinders communities from engaging in meaningful feedback with the institutions that are contracted to facilitate the rehabilitation of their community members[14]; and

Whereas, The lack of accountability and oversight of for-profit prisons allows for unchecked opportunities for profit-making, resulting in the exploitation and commodification of incarcerated individuals[13]; and

Whereas, In 2021, the Executive Order on Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities directed the Attorney General not to renew Justice Department contracts with privately operated criminal detention facilities[15]; and

Whereas, Such firms have begun to circumvent the order by engaging in intergovernmental service agreements with counties then contract directly with the federal government for immigration or marshals' detention services, demonstrating that additional policy is needed to prevent such loopholes[16]; and

Whereas, Several states, including California, Nevada, New York, Illinois, and Washington, have passed legislation aiming to reduce, limit or ban private prison companies from operating[17]; and

Whereas, Twenty-two U.S. states do not utilize private prisons at all, demonstrating that for-profit prisons are not necessary for the continuation of state legal system operations[18]; therefore be it

RESOLVED, That our AMA advocate against the use of for-profit prisons; and be it further

RESOLVED, That our AMA advocate for for-profit prisons to be held to the same standards as their public counterparts with respect to their oversight and reporting of health-related outcomes, until we move away from the use of for-profit prisons.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
CMS Rep. 02, I-16; Appended: Res. 417, A-19 Appended: Res. 420, A-19 Modified: Res. 216, I-19 Modified: Res. 503, A-21 Reaffirmed: Res. 229, A-21

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94 Amended: Res. 416, I-99 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation I-09 Modified in lieu of Res. 502, A-12 Reaffirmation: I-12

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993
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.
Res. 407, 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.
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

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Res. 017, A-17

Compassionate Release for Incarcerated Patients H-430.980
Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.
BOT Rep. 10, I-20

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 71
(A-23)

Introduced by: Sanjana Ravi, Canaan Hancock, Alma Rosa Rivera, Ayisha Mahama, William J. Austin, Chandana Tetali, Dell Medical School at The University of Texas at Austin; Whitney Stuard, University of Texas Southwestern; John Charles Nichols, Katie McMillan, UAB Heersink School of Medicine

Subject: Increasing Education About and Access to Supported Decision-Making Agreements (SDMAs)

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The American Disability Act (ADA) defines a person with disability as someone who has a physical or mental impairment that substantially limits one or more major life activities, has a history or record of such an impairment, or is perceived by others as having such an impairment[1]; and

Whereas, Over three million children (4.3% of minors) and 61 million adults (26% adults) in the United States had a disability in 2019[2-,4]; and

Whereas, Guardianship is a legal role that provides a designated individual the authority to make decisions for another person with a disability[5,6]; and

Whereas, The Individuals with Disabilities Education Act (IDEA) of 1990, established that schools will help students with disabilities and their parents throughout the minor-to-adult transition period before rights are transferred directly to the student, including counseling on guardianship[5]; and

Whereas, Research on the school-to-guardianship pipeline shows that 60% of people with intellectual and developmental disabilities ages 18 to 22 who receive publicly funded services have guardians and report that schools presented guardianship as the main or default option to support young adults in decision-making[5]; and

Whereas, Adult and minor-aged students with disabilities under guardianship lose their right to make decisions about their health, future education, and employment plans, thereby reducing an individual's right to self-determination, independence, and autonomy[5-8]; and

Whereas, Guardianships are difficult to reverse and leave people with disabilities vulnerable to both abuse from their guardians and having decisions being made against their will[8-14]; and

Whereas, Supported decision-making agreements (SDMAs) exist as an alternative to guardianship that maintain the autonomy of individuals with disabilities by establishing a collaborative agreement with a chosen team of people to make life decisions such as desired

housing location and potential housemates, desired social supports, desired medical decisions, etc.[15-17]; and

Whereas, Supported decision making is associated with significantly improved behavioral health among children with special healthcare needs[18]; and

Whereas, Twelve states already have comprehensive legislation implementing SDMAs as an alternative to guardianship, with a further nine states having introduced legislation in the coming cycle to expand their use[19-28]; and

Whereas, Under AMA policies H-90.967, "Support for Persons with Intellectual Disabilities," and 2.1.2, "Decisions for Adult Patients that Lack Capacity," the AMA supports efforts to ensure these individuals maintain as much independent function as possible, and are involved in the decisions for their care to a level proportional to their abilities[29,30]; and

Whereas, The American Academy of Pediatrics recommends the application of shared decision-making in daily clinical care of children with disabilities; therefore be it

RESOLVED, That our AMA advocates for the use of supported decision-making agreements (SDMAs) as an alternative to guardianship; and be it further

RESOLVED, That our AMA encourages schools to promote the full range of decision-making options for students with disabilities, including supported decision-making agreements; and be it further

RESOLVED, That our AMA will collaborate with the American Academy of Pediatrics to increase provider and trainee knowledge on the use of supported decision-making when caring for individuals with disabilities.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

2.1.2 Decisions for Adult Patients Who Lack Capacity
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf. When a patient lacks decision-making capacity, the physician has an ethical responsibility to: (a) Identify an appropriate surrogate to make decisions on the patient's behalf: (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate. (b) Recognize that the patient's surrogate is entitled to the same respect as the patient. (c) Provide advice, guidance, and support to the surrogate. (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on: (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record; (ii) the patient's views about life and how it should be lived; (iii) how the patient constructed his or her life story; and (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures. (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on: (i) the pain and suffering associated with the intervention; (ii) the degree of and potential for benefit; (iii) impairments that may result from the intervention; (iv) quality of life as experienced by the patient. (f) Consult an ethics committee or other institutional resource when: (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate; (ii) ongoing disagreement about a treatment decision cannot be resolved; or (iii) the physician judges that the surrogate's decision: a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred; b. could not reasonably be judged to be in the patient's best interest; or c. primarily serves the interests of the surrogate or other third party rather than the patient.

Medical Care of Persons with Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs

to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities. 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities. 3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them. 4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction. 5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community. 6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities. 7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities. 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities. 9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities. 10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population. 11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

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.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 72
(A-23)

Introduced by: Charlie Adams, Ashley Glass, Alexandra Simon, Yuan Xie, Kansas City University College of Osteopathic Medicine; Sarah Costello, University of Iowa Carver College of Medicine; Cecily Negri, Southern Illinois University School of Medicine; Jay Devini, University of Missouri School of Medicine; Carson Hartlage, University of Cincinnati College of Medicine; Jara Crawford, Indiana University School of Medicine

Subject: Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients

Sponsored by: Region 2, Region 4, Region 5, Region 7, Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The Electronic Health Record (EHR) system plays a vital role in helping doctors track patient demographics, clinical notes, diagnoses, and test results[1]; and

Whereas, EHR systems reflect an assumption that everyone is cisgender, and many EHRs do not provide sufficient flexibility or inclusivity for transgender and gender diverse (TGD) patients who do not fit into the traditional binary of sex and gender[2-4]; and

Whereas, Sex assigned at birth may inadequately describes current clinical sex for transgender patients whose medical transition altered their secondary sex characteristics, hormone levels, or genitals[4]; and

Whereas, Multiple studies have demonstrated that the changes in chemistry and hematology parameters from masculinizing and feminizing hormone therapies overall show good correlation with cisgender male and female reference values[5,6]; and

Whereas, The legal sex found on identity documents should not be used as a proxy for current sex because it can be clinically misleading in many circumstances[7]; and

Whereas, Both sex assigned at birth and current anatomy are needed to inform clinical decisions, while legal sex may be required for billing and insurance purposes[8,9]; and

Whereas, Due to a variety of financial and institutional barriers, many TGD people may not be able to formally change their legal name to reflect their chosen name; thus, their chosen name may not appear on insurance and medical documentation[10]; and

Whereas, In TGD patient chart notes, the correct pronouns are used less than 40% of the time, assigned sex at birth is recorded accurately less than 54% of the time and only 46% of TGD patients were recorded with the proper ICD codes[8]; and

Whereas, Gender identity data includes chosen name, pronouns, current gender identity, and sex listed on original birth certificate[11]; and

Whereas, The terms "sexual preference" and "preferred pronouns" suggest that being LGBTQ is a choice, while "chosen name" acknowledges that a name is more than a preference[12-14]; and

Whereas, Forty percent of TGD people attempt suicide within their lifetime, with young people being most likely to do so, and TGD youth who addressed by their chosen name experience lower rates of depression, suicidal ideation, and suicidal behavior[10,15]; and

Whereas, Misgendering is when a person is addressed or described with pronouns that do not reflect their gender identity[11], and is associated with experiences of depression, stress, and stigma[16,17]; and

Whereas, Deadnaming is a form of misgendering that often occurs in healthcare settings in which a transgender person is inadvertently addressed by their birth name which they no longer use, often triggering gender dysphoria[18]; and

Whereas, Storing gender identity data in inconsistent locations across EHR platforms and institutions adds further confusion to what is already a challenging topic for healthcare workers to understand[19]; and

Whereas, Twenty-three percent of TGD people have avoided necessary medical care due to fear of being disrespected or mistreated, with misnaming and misgendering cited as common reasons for doing so[10]; and

Whereas, Automated cancer screening reminders for TGD patients may cause discomfort and increased mistrust in medical professionals when the screening reminders are linked to sex assigned at birth instead of the patient's present organs; this can be prevented by organ inventories, which list the patient's present organs, and are recommended by the World Professional Association for Transgender Healthcare[2,8,20-22]; and

Whereas, Many TGD people undergo medical and surgical gender-affirming interventions including hormone replacement therapy, masculinizing chest surgery, breast augmentation, hysterectomy, and genital surgeries, which may lead to an organ inventory that does not align with the binary view of sex and gender upon which EHRs are structured[23]; and

Whereas, Patient sex as recorded in EHRs is used to generate health screenings, medication dosages, and laboratory test ranges by taking into account assumed hormonal history and anatomy typical for the specified sex[24]; and

Whereas, TGD people with a uterus have a 37% lower odds of being up to date on their Pap testing compared with cisgender people[25-28]; and

Whereas, Incorrect application of sex-based risk stratification tools for bone health[29] and cardiovascular disease[30], predicting hypoxemia in anesthetized patients during surgery[4], and estimated glomerular filtration rate[31] further compound poor TGD health outcomes[10]; and

Whereas, Over half of healthcare professionals reported their EHRs have one field for both sexual orientation and gender identity rather than separate fields for each, only 27% had the ability to record patient pronouns, and 55% had the ability to record chosen name[19]; and when

EHRs have inclusive options, these features are often hidden behind a paywall or only available through opting in to turn the features on[32]; and

Whereas, Only 10-20% of customers utilize trans-inclusive options in EHRs that have them, and only a quarter of all patients have their gender identity listed in the EHR[9,33]; and

Whereas, Our AMA policy D-478.995 urges EHR vendors to adopt social determinants of health templates without adding further cost to medical providers; and

Whereas, Our AMA policy H-315.967 advocates for the inclusion of gender identity-related demographics in medical documentation and incorporation of recommended best practices into electronic health records; however, the suggestions for what to include leave an incomplete picture of transgender patients' medical history, leading to unhelpful ambiguity of advocacy efforts; therefore be it

RESOLVED, That our AMA will amend policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows.

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

Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3) Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (~~4~~5) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically.

; and be it further

RESOLVED, That our AMA advocates for increased education and training on usage of gender identity and related transgender-inclusive functions in electronic healthcare records within healthcare institutions; and be it further

RESOLVED, That our AMA advocates for easy transferability of transgender-inclusive functions between different electronic healthcare record systems and that this transfer capability is included in the healthcare institutions' training and education for staff; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974
Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” to our membership.

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.

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician

Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual’s right to determine their stated sex marker or gender identity.

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.

EHR Interoperability D-478.972
Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 73
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Hailey Baker, University of Minnesota Medical School; Katie Wilson, University of Minnesota Medical School; Canaan Hancock, Dell Medical School at UT-Austin; Anna Klunk, Philadelphia College of Osteopathic Medicine, Brianna Baldwin, University of Virginia School of Medicine

Subject: American Indian and Alaska Native Language Revitalization and Elder Care

Sponsored by: Region 1, Region 2, Region 3, Region 6, Association of Native American Medical Students, PsychSIGN

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, American Indian and Alaska Native (AI/AN) people suffered serial decreases in life expectancy from 2019 to 2022, with the life expectancy in 2021 at birth of 65.2 years, equal to the life expectancy of the U.S. population in 1944[1]; and

Whereas, Language and cultural barriers have been shown to lower health literacy and restrict AI/AN elder access to federal and state programs for which they are eligible, including Medicare, Medicaid, and Social Security[2]; and

Whereas, Over 1 in 5 AI/AN elders over the age of 65 predominantly speak their native language in the home, and in several counties on the Navajo Nation, 43.4% of people speak their native language as their primary language[3]; and

Whereas, AI/AN elders are less likely to have advance care planning in place compared to the general population, and most elders proceed with alternative means of end-of-life care with familial assistance, both of which require interpreter services for thoughtful and well-informed care planning during emergency critical care or hospice conversations[4-5]; and

Whereas, Healthcare conversations on severe or chronic illness, death, or dying are considered taboo or uncomfortable to many people, some AI/AN communities included, and therefore require an understanding of language and cultural context to navigate these difficult topics[6]; and

Whereas, Communication with AI/AN elders involves nuances that comes with both navigating difficult conversation and understanding key components of native culture that would greatly improve the experience in discussing end of life decisions, including, but not limited to, cultural competency in regards to non-verbal cues; rich use of metaphor and storytelling (as is custom in many native cultures); references to traditional medicine that are enriched by interpreters originating from within the community wherein that language is predominant[7]; and

Whereas, AI/AN elders are disproportionately impacted by the lack of interpreters with sufficient cultural competency to effectively and compassionately navigate these conversations with patients, loved ones, and community[6]; and

Whereas, Although many AI/AN rely on family as interpreters, structures of colonialism and forced assimilation, such as boarding schools in the United States and Canada, have led to the intended erasure and endangerment of many Indigenous languages, with subsequent deprivation of competency in the children and grandchildren of AI/AN elders[8-9]; and

Whereas, In a qualitative study, AI/AN elders discussed that healing from intergenerational historical trauma and maintaining wellness involves tribal cultural reclamation, including speaking one's Native language in the community[10]; and

Whereas, A survey study found that AI/AN adults who could speak their Indigenous language were more categorizes as part of the "good" wellness group (82.4%) than those who could not speak their Indigenous language (70.1%)[11]; and

Whereas, In the wake of the Navajo Nation suffering the highest per capita coronavirus infections in the United States during the height of the COVID-19 pandemic in June 2020, the Indian Health Service and Navajo Dept of Health determined an effective means of communication with elders was to create COVID-19 materials and broadcast COVID-19 education via radio in the Navajo language to the community[12-14]; and

Whereas, There is a current shortage in a database, studies, or resources identifying the availability of AI/AN interpreter services per service population at the Indian Health Service as well as rural and urban Indian health clinics; and

Whereas, Article 13 of the United Nations Declaration on the Rights of Indigenous Peoples, an international framework approved by the United States, specifies that Indigenous Peoples have the right to revitalize, use, develop and transmit to future generations their languages[9]; and

Whereas, The National Indian Council on Aging cite speaking Native languages as a key component of improved comprehensive health, social services, and well-being for AI/AN elders[15]; and

Whereas, A systematic review found that language use and revitalization serve as protective factors in the health of AI/AN populations, improving both general and mental health, as well as assisting in the ability of individuals to achieve academic goals, a known social determinant of health[16-17]; and

Whereas, The Health Resources Services Administration (HRSA) recommends taking into account historical inequities and cultural factors, such as language to deliver culturally informed and responsive healthcare to Native elders[18-19]; and

Whereas, The AMA H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured 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; and

Whereas, The AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory

impairments (H-160.924) and 8.5 Disparities in Health Care (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; and

Whereas, In 2022, the White House Office of Science and Technology Policy (OSTP) released the first-ever federal guidance for federal departments and agencies on Indigenous knowledge[20]; and

Whereas, The OSTP has directed federal agencies, including the Department of Health and Human Services, Center for Medicare and Medicaid Services, and Indian Health Service, to recognize value, and include Indigenous knowledge, including languages and knowledge holders, in federal grantmaking and other funding opportunities[20]; and

Whereas, The OSTP says that including Indigenous knowledge in federal grantmaking will facilitate exploration of new lines of research and development, which may help close evidence gaps for AI/AN health services[20-21]; and

Whereas, The OSTP has directed federal agencies to value Indigenous knowledge on par with other forms of evidence and methods of evidence-generating inquiry and not disadvantage or bias against Indigenous knowledge in the review process[20]; therefore be it

RESOLVED, That our AMA will study the 2022 White House Office of Science and Technology Policy Guidance for Federal Departments and Agencies on Indigenous Knowledge and support convention of healthcare organizations, tribal leaders, and tribal-serving organizations with focuses on, but not limited to:

a. Integrating Indigenous knowledge and cultural competence into health care services delivery for American Indian and Alaska Native patients living in rural, urban, and tribal areas
b. Identifying best practices for American Indian and Alaska Native elder health care, especially on language-concordant health care services
c. Assess the historical and ongoing economic impact of tribal set-asides in healthcare funding and funding opportunities for tribes in HRSA, IHS, and CMS grantmaking; and be it further

RESOLVED, That our AMA recognizes that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors; and be it further

RESOLVED, That our AMA will partner with stakeholder organizations to encourage advance care planning for American Indian and Alaska Native elders with incorporation of patients' cultural values and priorities; and be it further

RESOLVED, That our AMA will support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-350.976 Improving Health Care of American Indians

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens; (2) The federal government provide sufficient funds to support needed health services for American Indians; (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in

an effort to improve their quality of life; (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs; (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians; (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents; (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems; (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians; (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside; (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians; (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

H-350.977 Indian Health Service

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be

given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

D-350.987 Strong Opposition to Cuts in Federal Funding for the Indian Health Service

Our AMA: (1) will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; (2) Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service; (3) Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction; (4) In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service; (5) Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

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.

H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 74
(A-23)

Introduced by: Druv Bhagavan, Washington University in St. Louis School of Medicine

Subject: Allowing Exemptions to Mandatory Student Health Insurance Plans

Sponsored by: Region 1, Region 2

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Medical students come to medical school with different financial backgrounds, parental support, and healthcare needs; and

Whereas, 14.6% of U.S. allopathic medical students in 2017-2019 reporting parental household income in the lowest two quintiles[1]; and

Whereas, The fraction of matriculants reporting parental household income within the lowest quintile (6.1%), roughly corresponding to the Federal Poverty Level (FPL) for a family of four[2,3], is significantly overrepresented among those who identify as Non-Hispanic White (3.5%), Non-Hispanic Asian (7.0%), Hispanic (10.7%), and Non-Hispanic Black (14.1%)[1]; and

Whereas, 4.9% of U.S. allopathic medical students reported disabilities and chronic health conditions in 2019, which represents a significant increase from 2016 and may be a substantial underestimate of true prevalence[4]; and

Whereas, Student loans do not count towards Annual Gross Income (AGI), so medical students and their families may qualify for Medicaid and/or purchase an ACA Marketplace plan; and

Whereas, Medicaid and CHIP eligibility levels vary significantly by state, with median eligibility cutoffs for low-income adults and parents in states with Medicaid Expansion under the Patient Protection and Affordable Care Act (ACA) at 138% FPL and parents in states without ACA Medicaid Expansion at 41% FPL; and

Whereas, Medicaid and CHIP eligibility levels are zero for childless low-income adults (who are not eligible) in states without ACA Medicaid Expansion[5]; and

Whereas, Individuals and families making between 100% (138% in states with ACA Medicaid Expansion) and 400% FPL (temporarily uncapped for 2021 and 2022 due to the American Rescue Plan Act) are eligible for the premium tax credit, which subsidizes the cost of ACA Marketplace plans[6]; and

Whereas, Lawfully present immigrants and international students with valid student visas may qualify for premium tax credits on ACA Marketplace plans, though they may not qualify for Medicaid and CHIP[7]; and

Whereas, Medical students who gain income from self-employment and do not qualify for other health insurance programs are eligible to deduct all medical and dental expenses for themselves and their family (including premiums) exceeding 7.5% of AGI[8]; and

Whereas, Patients on Medicaid within 5 percentage points of FPL incur significantly lower out-of-pocket costs than those on ACA Marketplace plans[9]; and

Whereas, Medical students may obtain coverage through their parents' health insurance plan (if applicable) until age 26, per the ACA[19]; and

Whereas, Universities are not required to offer student health insurance plans but frequently mandate health insurance as a condition of enrollment[10]; and

Whereas, Student health insurance plans offered by colleges and universities must be fully compliant with the ACA's individual market requirements (except for merging risk pools in their state, fitting into actuarial value ranges, and the federal rate review process), unless they are self-insured plans[11]; and

Whereas, Medical schools vary significantly in their policies with respect to student health insurance waivers, with some allowing broad exemptions (including Medicaid, CHIP, ACA plans, and employee-sponsored insurance), some excluding Medicaid or individual plans specifically, and others allowing no exemptions whatsoever[12-16,18]; and

Whereas, In 2020-2021, depending on program ownership type and student state resident status, median annual costs of medical student health insurance plans were $3,000-4,000, maximum costs were $6,500-7,000, and this represented an increase of 4.6-12.1% over the previous year [17]; and

Whereas, Medical students may therefore be forced to pay higher premiums for a student health insurance plan that, if self-funded, does not need to meet minimum essential coverage under the ACA while eligible for Medicaid or ACA Marketplace plans, which do meet that coverage[19, 20]; and

Whereas, This represents a substantial financial burden on medical students and exacerbates existing socioeconomic disparities; and

Whereas, The AAMC Group on Student Affairs recommends that "medical students should be allowed to select a personal policy after providing documentation that the policy provides comparable coverage"[21]; and

Whereas, Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," states that "the costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty," and urges strong advocacy in tandem with relevant stakeholders to fulfill this principle; and

Whereas, Policy H-295.942, "Insurance Coverage for Medical Students and Resident Physicians," urges all medical schools to offer or pay for affordable health insurance options for medical students and suggests guidelines for coverage, but does not address exemptions from otherwise mandatory student health insurance plans for students who may qualify for other, potentially cheaper, health insurance with equal or greater coverage; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to urge medical schools to allow students and their families who qualify for other health insurance with equal or greater coverage, including Medicaid, Children's Health Insurance Program (CHIP), or an Affordable Care Act (ACA) Marketplace health insurance plans, to be exempt from otherwise mandatory student health insurance plans.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical **student** debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National **Health** Service Corps, Indian **Health** Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of **Health** programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National **Health** Service Corps Loan Repayment Program to assure adequate funding of primary care within the National **Health** Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in **health** professions shortage areas.

5. Encourage the National **Health** Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of **student** loan savings accounts that allow for pre-tax dollars to be used to pay for **student** loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on **student** loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty

medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical **student** borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical **student** fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the **student** loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical **student** loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid **student** loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical **student** and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical **student** engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment **plans** for the benefit of reducing medical **student** load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their **student** loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Insurance Coverage for Medical Students and Resident Physicians H-295.942

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance **plans** by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such **plans**; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable **health** insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided **health** insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for **health** insurance providing the minimum benefits recommended by the AMA for employer-provided **health** insurance; and (b) include in all such policies a rollover provision allowing continuation of **student** disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group **health** and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable **health** and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and **health** insurance and describing the available coverage and characteristics of such insurance.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 75
(A-23)

Introduced by: Narmeen Rehman, Trisha Gupte, Lauren Kasmikha, Wayne State University

Subject: Support Development of Sickle Cell Disease Comprehensive Care Centers

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Sickle cell disease (SCD) is the most prevalent inherited blood disorder in the United States, affecting approximately 100,000 individuals, with a disproportionate impact on individuals of African and Hispanic descent [1,2]; and

Whereas, SCD has a significant burden on a patient's health and quality of life – as its clinical manifestations can include a range of complications (eg: stroke, kidney failure, increased risk of infection) that result in an average life expectancy of 54 years which is approximately 20 years less compared to adults without SCD [3,4]; and

Whereas, Sickled cells occlude blood vessels resulting in profound ischemia and inflammation causing chronic pain and acute vaso-occlusive crises, which drive acute care utilization higher in this population with 80% of medical expenses for patients with SCD stemming from Emergency Department (ED)-based admissions[5,6]; and

Whereas, In addition to physical symptoms, patients with SCD face significant obstacles in accessing quality care due to multiple barriers including: lack of specialized care with many providers lacking expertise, resources, or guidelines for adequate treatment, biases and stigma from healthcare providers, geographic barriers to care, limited research to inform evidence-based guidelines for care[7];and

Whereas, Multiple studies show provider discomfort with managing SCD pain due to limited exposure which differs by specialty - with one study showing 20% of primary care providers felt comfortable with the management of SCD because little saw more than five patients with SCD[8–11]; and

Whereas, A majority of patients with SCD have experienced chronic pain throughout their lives and developed coping mechanisms that may mask the outward appearance of distress which can lead to healthcare professionals underestimating the severity of pain they experience, or unfortunately distrust patient-reported pain, mislabeling patients as drug-seekers, harming the doctor-patient relationship, and preventing adequate pain management and palliative care[12–16]; and

Whereas, Mistrust furthers the stigma against patients with SCD and as a result patients tend to delay care – a study finding that a majority of young adults with SCD (88%) tend to delay seeking medical care until their pain reaches an average score of 8.7 out of 10 on a pain scale

due to the fear of stigma associated with seeking medical attention which can lead to severe complications, highlighting the impact of trust in medical providers for patient outcomes in this population [17,18]; and

Whereas, The National Sickle Cell Disease Control Act in 1972 established ten SCD centers with a triple-aim to conduct research, provide care, and collaborate with community organizations primarily in pediatric populations which played a key role in development of guidelines that were successful in reducing mortality through longitudinal early screening and treatment, effectively playing a key role in elongating the life-span of patients with SCD [20 -21]; and

Whereas, Comprehensive sickle cell care centers provide interdisciplinary services for patients with SCD across the lifespan led by SCD specialists which include health maintenance and preventive care (genetic testing, chronic transfusion, stem cell therapies), medical subspecialty care (support from stroke neurologists, pulmonologists, nephrologists), behavioral health (support for depression, anxiety which is often comorbid in this population) radiology, pain specialists, surgical specialists, education and vocational services (which provide support to patients whose work may be impacted by their condition), research, and data management[19–21]; and

Whereas, Comprehensive care programs have direct expertise working with the many complex, multi-faceted complications of SCD, and have been shown to have for better disease control, fewer acute care hospitalizations, fewer inpatient admissions, decreased healthcare costs overall, and decreased life-threatening adverse events such as acute chest syndrome [19,21–26]; and

Whereas, One notable example is the Sickle Cell Center for Adults at Johns Hopkins which offers comprehensive services such as outpatient visits, hydroxyurea management, genetic counseling, social services, and acute pain management transfusion centers; This center has been instrumental in reducing admission rates in the Emergency Department and on a broader-scale led to a 7% annual reduction in the likelihood of hospital readmission for the city of Baltimore [20]; and

Whereas, Studies show comprehensive treatment programs also address the trust deficit patients with SCD face by connecting them with providers who are more experienced working with SCD, as research finds patients who receive their care at specialized SCD centers have higher trust in their providers which is linked to improved adherence to treatment plans and thus better health outcomes compared to patients who are not treated at specialized SCD centers; additionally, patients treated at SCD centers reported facing less discrimination and overall higher patient satisfaction scores [27–30]; and

Whereas, Despite the efficacy of comprehensive treatment centers, today, there are only 75 comprehensive sickle cell treatment centers and only 17 of these provide care across the continuum for pediatric and adult patients. This is dangerous as the transition from pediatric to adult care has been associated with a seven-fold increase in mortality due to factors such as

interruption of critical therapies such as hydroxyurea and transfusion, lack of appropriate training on childhood-onset conditions among adult-focused healthcare providers, and health system barriers [1,32–34]; and

Whereas, Comprehensive care centers have shown great benefit for other rare conditions, such as Cystic Fibrosis which has nearly double the number of comprehensive care centers as SCD despite SCD being 3.3 times more prevalent, highlighting the well-supported disparity in the funding and support for SCD compared to other rare diseases [34–36]; and

Whereas, The inadequate geographic distribution of these comprehensive treatment centers significantly hinders access to care for patients with SCD; currently, eight states have zero comprehensive sickle cell centers and many others with only one serving the whole state – such a poor geographic distribution can create further disparities within this population, making it critical to support the development of additional comprehensive care centers to reach areas not currently served[1]; and

Whereas, There are policies in Congress, including the Sickle Cell Disease Treatment Centers Act of 2022, which aims to increase the number and support for sickle cell treatment centers given their potential to improve the access and quality of SCD care for patients with SCD[37]; therefore be it

RESOLVED, That our AMA supports the establishment of comprehensive sickle cell treatment care centers to address critical care gaps that patients with sickle cell disease (SCD) face and improve both the quality of care and life for patients affected by SCD.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Physician-Led, Single and Multi-Specialty, Organized Group Practice Models H-390.843

1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care.

2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost.

Eliminating the Barriers to Surviving Acute Myocardial Infarction D-160.946

Our AMA will: (1) work with relevant societies to conduct a thorough analysis of the geographic, economic and political barriers to optimal care for the ST-elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission; political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms; (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the geographic, economic and political barriers to optimal care for the STEMI patient that currently exist; (3) encourage the standardization of pre-hospital and in-hospital care for cardiac emergencies, to improve care and enhance survival for all patients, especially for those who receive socioeconomically, geographically, and demographically disparate care, when they present with ST Elevation Myocardial Infarction (STEMI), STEMI with cardiogenic shock (STEMI-CS), and Out of Hospital Cardiac Arrest (OHCA); and (4) encourage regional or national hospital designation or categorization systems for Emergency Cardiac Care Centers based on their individual capabilities to provide ECC, analogous to hospital designations or categorizations and systems of care for stroke and trauma.

Sickle Cell Disease H-350.973

(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education

during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and (8) encourages the development of model school policy for best in-school care for children with sickle cell disease.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 76
(A-23)

Introduced by: Pali Keppetipola, Marwah Shuaib, The George Washington School of Medicine and Health Sciences

Subject: Community-Based Pregnancy Support for Refugee and Asylum-Seeking Women

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, According to the United Nations Refugee Agency (UNHCR), there are approximately 40 million refugee women, the majority of them being of childbearing age, displaced within their own countries (internally displaced persons or IDPs) or across national borders worldwide[1]; and

Whereas, Refugee women face barriers to obtaining reproductive healthcare and can experience worse pregnancy-related outcomes compared to the U.S.-born and other immigrant women, most frequently including but not limited to preterm birth, preeclampsia, and postnatal depression[2,3]; and

Whereas, Refugee women are confronted with obstacles when it comes to receiving prenatal care, including inability to afford or schedule appointments until later in pregnancy, poor communication with physicians due to language and cultural barriers, and lack of continuity of care due to relocations caused by the asylum process[2]; and

Whereas, Additional considerations of barriers to reproductive healthcare for refugee women include the difficulty of having consistent access to in-person interpreters at healthcare facilities and clinics, low engagement with referral and follow-up appointments due to transportation and logistical difficulties on the part of patients, and structural and financial constraints of the facilities that provide sexual and reproductive healthcare services to refugee women[4]; and

Whereas, The concept of community-support programs specific to pregnancy and postpartum care has been successfully executed in a variety of settings working with new immigrant groups[5]; and

Whereas, Such community support programs have resulted in improved outcomes for birthing women including higher attendance at prenatal visits, decreased rates of preterm labor and birth, and increased breastfeeding initiation rates, highlighting the critical role that community-based education and mentorship can play in optimizing care and outcomes for pregnant people and their children[6]; and

Whereas, The intention of such programs is to fill gaps that are not comprehensively met through pre-existing social and clinical support systems including free or low-cost health clinics, nonprofit organizations, and faith-based organizations, and to provide women with welcoming,

non-judgmental spaces where they can connect and communicate with other women going through the experiences of pregnancy and childbirth amid displacement, as well as access to guidance and support from clinicians and advocates trained in trauma-informed practices[7]; and

Whereas, It has been shown that participants in a qualitative study of community-based prenatal services for refugee women in Australia reported improved social support, greater continuity of care, increased knowledge about pregnancy outcomes, greater confidence to ask questions and advocate for their own health, increased trust in their care providers, and more assistance with other life challenges such as transportation and language services[2]; and

Whereas, Community-based, culturally tailored programs like Embrace Refugee Birth Support in the state of Georgia (U.S.) showed positive trends in improved birth outcomes such as reduced labor induction, which supports findings for higher gestational age at birth and birthweight, as well as lower risk of cesarean delivery[2] (which refugee women from Southeast and Central Asia experience at higher rates[8]); and

Whereas, Overall, studies have shown that community and evidence-based pregnancy support programs have robust potential to enhance coordination of care for vulnerable women, and stronger evidence on reproductive health disparities and prenatal community-based interventions would be beneficial in the wide-scale implementation of such programs[2,7,9]; and

Whereas, The value that community-based support programs can provide for birthing and non-birthing individuals is immense - however, these programs are generally few and far between due to logistical and financing challenges, and would benefit from greater funding and research support[4]; and

Whereas, Current AMA policy encourages involvement in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants (H-420.978, H-420.972, H-185.917, H-350.957, 250.020MSS, 245.012MSS); and

Whereas, Refugee and asylum-seeking populations can be targeted more effectively and specifically via the expansion of a community-based approach to prenatal and postnatal care for birthing individuals that can be achieved by widespread research and systematic support by healthcare entities as outlined above; therefore be it

RESOLVED, That our AMA supports increased research funding evaluating the efficacy and impact of community-based support programs on large-scale birth and post-pregnancy outcomes for vulnerable populations.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Access to Prenatal Care H-420.978
(1) The AMA supports development of legislation or other appropriate means to provide for access to **prenatal** care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to **prenatal** and natal care be taken into account.
Reaffirmed: BOT Rep. 7, A-21

Prenatal Services to Prevent Low Birthweight Infants H-420.972
(1) Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at **prenatal** services for pregnant women, particularly women at risk for delivering low birthweight infants.
Reaffirmed: CSAPH Rep. 1, A-21

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917
(7) Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
(8) Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, **prenatal**, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
Joint CMS/CSAPH Rep. 1, I-21

Addressing Immigrant Health Disparities H-350.957
(1) Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
(2) Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
(3) Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Reaffirmation: I-19

250.020MSS Refugee Health Care
AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

245.012MSS Continuing the Fight to Lower Infant Mortality in the United States
AMA-MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, ... and research on how to best reduce infant mortality. AMA-MSS will communicate to the AMA Health Disparities Initiative and/or AMA Chief Health Equity Officer the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 77
(A-23)

Introduced by: Shriya Veluri, Jonathan Dao, Leslie Omeire, University of Texas Health Science Center San Antonio, Long School of Medicine

Subject: Supplemental Breast Cancer Screening for People with Dense Breast Tissue

Sponsored by: Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Breast cancer is the most commonly occurring cancer in women and the leading cause of mortality as well as disability-adjusted life-years (DALYs), calculated as the sum of years of healthy life lost due to cancer-related disability and years of life lost due to premature mortality from breast cancer, with 1.7 million incident cases, 535,000 deaths, and 14.9 million DALYs[1,2]; and

Whereas, Mammographic breast density (>25 percent dense tissue) is one of the strongest risk factors for breast cancer, with a four- to six-fold increased risk of developing breast cancer compared to those with non-dense breasts[3]; and

Whereas, The Breast Imaging Reporting and Data System (BI-RADS) is a tool to standardize mammogram reports, in which breast composition falls into four categories ranging from BI-RADS 1, meaning entirely fatty tissue, to BI-RADS 4, meaning extremely dense breast tissue[4]; and

Whereas, Over 40% of women have dense breasts, and these individuals are disproportionately affected by underdiagnosis of malignancy due in part to masking of tumors on mammography, which can result in disease progression to more invasive cancers with poor prognosis[5]; and

Whereas, Mammography showed a 41% reduction in mortality in women with non-dense breasts but only a 13% reduction in women with dense breasts, indicating that all women do not benefit equally from mammography screening[6]; and

Whereas, The sensitivity of mammography, defined as the ability of mammography to correctly classify or identify an individual as diseased, decreases from 78% for individuals with BI-RADS 1 classification to 47% for individuals with BI-RADS 4[7]; and

Whereas, High sensitivity values are associated with more true positive results and fewer false negative results, optimizing early disease detection[8]; and

Whereas, The American College of Radiology recommends supplemental MRI screening in average-risk, intermediate-risk, and particularly high-risk individuals with dense breasts[9]; and

Whereas, The Chinese Anti-Cancer Association recommends supplementary breast ultrasonography (BUS) after two negative mammograms in women with dense breast tissue[11,12]; and

Whereas, The European Society of Breast Imaging has recommended supplemental magnetic resonance imaging screening for high risk individuals with dense breast[3]; and

Whereas, Models have shown that magnetic resonance imaging (MRI) screening is more cost effective than mammography for women with dense breast tissue when taking into account lives saved and quality-adjusted life-years (QALYs), which is calculated by combining the effects of a health intervention on mortality and morbidity[10]; and

Whereas, The sensitivity of supplemental MRI in patients with extremely dense breasts is 95.2% and the specificity of supplemental MRI is 92%, allowing for increased detection of early-stage cancers as compared to mammography-only screening[13]; and

Whereas, Mammography-only screening resulted in an interval-cancer rate of 5.0 per 1000 screenings but supplemental MRI screening resulted in an interval-cancer rate of 2.5 per 1000 screenings, indicating a decrease in interval-cancers and a reduction in morbidity and mortality[13];and

Whereas, The sensitivity of supplemental BUS was 96% and the specificity of supplemental BUS is 88% in women with dense breasts and initially negative mammogram results[14]; and

Whereas, Nearly 90% of women are unaware of newly implemented breast density legislation, evolving screening guidelines, and the benefits and adverse effects of supplemental screening modalities[15]; and

Whereas, Dense breast notifications (DBNs) may increase awareness of an individual's breast density but does not necessarily increase health literacy regarding the implications of high breast density[16]; and

Whereas, Only 10% of individuals at a safety net hospital who received DBNs were able to recall the increased breast cancer risk associated with dense breast tissue and only 34% recalled the recommendation to speak to a healthcare provider regarding supplemental screening options, leading to inadequate usage of supplemental screening[17]; and

Whereas, An analysis of 22 patient education resources were reported to include excessive medical jargon, which can cause unnecessary worry regarding this information as well as a limited understanding of its clinical implications[16]; and

Whereas, The lack of promoting patient education and engagement can lead to incomplete self-health management and incomplete health care utilization resulting in adverse health outcomes[18]; and

Whereas, Women report that being better informed about the implications of breast tissue density and available resources, such as supplemental screening, can help combat anxiety associated with the mammography and breast density reports[19]; and

Whereas, A number of studies have shown that there is often a lack of knowledge on state mandates of reporting dense breast tissue (approximately 50% of primary care providers in New

York and California), and 67% of respondents felt they needed more education on breast density and supplemental imaging[20]; and,

Whereas, Only 19.2% of physicians and advanced care practitioners correctly identified supplemental screening guidelines for individuals with high lifetime risk of breast cancer[21]; and

Whereas, Healthcare professionals should be knowledgeable about the screening guidelines, efficacy, cost-effectiveness, and insurance coverage of various supplemental screening modalities in order to facilitate individualized discussions with patients[22]; and

Whereas, AMA Policy H-525.993 supports seeking recommendations from other health organizations regarding breast cancer screening guidelines and encourages periodic reconsideration of existing guidelines as new data becomes available; therefore be it

RESOLVED, That our AMA encourage the development of patient education materials regarding breast density, including the increased risk of missing breast cancer on screening mammography and appropriate supplemental screening; and be it further

RESOLVED, That our AMA supports education for healthcare professionals, both in training and in practice, regarding breast cancer screening guidelines for individuals with dense breasts; and be it further

RESOLVED, That our AMA amend policy H-525.977 Breast Density Notification by addition as follows:

Breast Density Notification, H-525.977
1. Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients.
2. Our AMA encourages research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based care and insurance coverage of the service.
3. Our AMA supports insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a discussion between the patient and their physician which integrates secondary risk characteristics.
4. Our AMA recognizes that dense breast tissue is one of many secondary risk characteristics for breast cancer; and be it further

RESOLVED, That our AMA amend policy H-525.993 Screening Mammography by addition as follows:

Screening Mammography, H-525.993
Our AMA:
a. recognizes the mortality reduction benefit of screening mammography and adjunctive screening methods and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.

c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography and adjunctive screening methods in reducing breast cancer mortality, as well as its limitations.
d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. encourages physicians and patients to consider supplemental screening modalities, such as screening MRI and breast ultrasound, for patients with dense breast tissue.
i. supports insurance coverage for screening mammography.
j. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
k. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Breast Density Notification, H-525.977
1. Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients.
2. Our AMA encourages research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based care and insurance coverage of the service.
3. Our AMA supports insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a discussion between the patient and their physician which integrates secondary risk characteristics.
Res. 502, A-14; Appended: Alt. Res. 803, I-18

Safety and Performance Standards for Mammography, H-525.985
Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks;
(2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals;
(3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and
(4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography.
BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep.1, A-21

Guidelines and Medicare Coverage for Screening Mammography, H-525.986
Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age.
BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep.1, A-11; Reaffirmed: CSAPH Rep.1, A-21

Screening Mammography, H-525.993
Our AMA:
a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.

d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. supports insurance coverage for screening mammography.
i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.
CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12; Reaffirmed: Alt. Res. 803, I-18

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.
CCB/CLRPD Rep. 3, A-14

Mammography Screening for Breast Cancer, D-525.998
In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services.
Res. 120, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Reaffirmed: B

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 78
(A-23)

Introduced by: Elisabeth McCallum, University of California, Irvine School of Medicine; Yuan Xie, Kansas City University College of Osteopathic Medicine; Sarah Costello, University of Iowa Carver College of Medicine; Rajadhar Reddy, Baylor College of Medicine; Julia Houshmand, University of Miami Miller School of Medicine; Aarti Patel, Wayne State University School of Medicine; Shaylyn Fahey, Virginia Tech Carilion School of Medicine;

Subject: Coverage for Care Provided After Sexual Assault

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, More than one in two women and one in three men have experienced sexual assault in their lifetime[1,2]; and

Whereas, Immediate consequences of a sexual assault include sexually transmitted infections (STIs) and sexually transmitted diseases (STDs), unintended pregnancy, and injuries sustained during the assault[3]; and

Whereas, The initial work up for a patient presenting after a sexual assault includes pregnancy assessment and prevention, STD/STI testing and empiric treatment, assessment and treatment of physical injuries, psychological assessment, and imaging if indicated by the physical exam, in addition to the forensic exam[4]; and

Whereas, Examination of over 112,000 emergency room visits utilizing sexual assault codes demonstrated an average cost of all services of $3,511, and $4,553 for patients who were sexually assaulted while pregnant[5]; and

Whereas, 60-70% of patients presenting to the Emergency Department have an income within the lowest two quartiles, and are less likely to have the financial means to pay the substantial costs associated with care[6]; and

Whereas, 16% of patients presenting to the Emergency Department following a sexual assault are uninsured, and are expected to pay most of these costs out-of-pocket[7]; and

Whereas, The Violence Against Women Act (VAWA) authorizes federal funds to be used for services to aide individuals who are victims of sexual violence[8]; and

Whereas, The VAWA ensures patients do not incur costs for the Medical Forensic Exam, which includes at minimum a medical history, physical exam, and collection of evidence; however, individual states decide coverage of any additional care related to the assault[8]; and

Whereas, While 51 states cover the cost of a Medical Forensic Exam for a patient presenting following a sexual assault, fewer than 19 states cover the cost of pregnancy and STD/STI testing, fewer than 17 states cover the cost of HIV prophylaxis, emergency contraception, and drug testing, and fewer than 4 states cover the cost of ambulance fees, procedures and imaging[8]; and

Whereas, Seventeen states place a monetary cap on the coverage for all services related to the sexual assault, including evidence collection, with many states capping coverage at $1,000 per survivor[8]; and

Whereas, 66% of women who presented to the ED following a sexual assault were charged out-of-pocket costs for the minimum services included in the Medical Forensic Exam[8]; and

Whereas, Over 80% of women who presented to a healthcare setting following a sexual assault incurred substantial out-of-pocket costs for care related to the sexual assault, but not directly relevant to obtaining evidence for legal purposes, including STI testing, pregnancy testing, and medications[8]; and

Whereas, Medical Forensic Exams performed by any healthcare professional other than Sexual Assault Forensic Examiners (SAFEs) are often not eligible to be covered through the VAWA act[8]; and

Whereas, There are over 6,000 hospitals in the US, but only around 900 programs training SAFE providers, which leads to some survivors traveling over 2 hours to reach a hospital where a SAFE is provided[8]; and

Whereas, AMA policy "Sexual Assault Survivors H-80.999" states that the AMA will work with state medical societies to ensure that each state implements the right to receive a medical forensic examination free of charge, however, does not call for the coverage of all medical services related to the assault, including transportation, imaging, procedures, and other services not covered in the forensic evaluation; therefore be it

RESOLVED, That AMA policy H-80.999 "Sexual Assault Survivors" be amended by addition to include coverage for additional services following a sexual assault to reduce patient costs, as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing <u>and prevention, drug testing,</u> treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will support efforts to cover the cost of all medical care involved in the immediate management of all patients presenting after a sexual assault, regardless of insurance status.
4. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
5. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
6. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

HIV, Sexual Assault, and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 79
(A-23)

Introduced by: Sneha Krish, Virginia Commonwealth University/MCV School of Medicine;
Shriya Veluri, University of Texas Health Science Center at San Antonio

Subject: Expanding Access to Hemorrhage Control Kits

Sponsored by: Region 3, Region 4, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, According to the World Health Organization, severe trauma - both unintentional and violence-related - results in the death of over 5 million people annually and is responsible for an estimated 10% of global years lived with disability[1]; and

Whereas, Hemorrhage secondary to this severe trauma is the leading cause of death until the age of 45, accounting for 35% of injury-related mortality in the United States[2]; and

Whereas, Many hemorrhage-related deaths occur prior to patients reaching the hospital for comprehensive care, primarily in high traffic locations such as schools and universities, places of worship, theaters, and venues of large gatherings[3]; and

Whereas, In rural regions of the country that have greater barriers to accessing upper-level trauma care, pre-hospital mortality from hemorrhage is 14% higher with emergency medical services (EMS) response times delayed by 14 minutes when compared to large, centralized metropolitan counties[4-5]; and

Whereas, Bystander intervention in rapid point-of-injury hemorrhage control is an effective measure that has demonstrated a 4.5-fold decrease in the risk of hypovolemic shock[5-6]; and

Whereas, The National Security Council launched the Stop the Bleed (STB) campaign in 2016 with the goal of educating and equipping the public with techniques of appropriate hemorrhage control based on best-practice recommendations in the Hartford Consensus[4]; and

Whereas, While STB has increased awareness of life-saving trauma care and trained over 2.4 million people, only 21.8% of individuals reported being able to access hemorrhage control kits in buildings, with 50.8% reporting inadequate materials (tourniquets, wound-packing or pressure bandage, and gloves) upon receipt[4,7]; and

Whereas, Basic hemorrhage control kits are still not available for purchase in common retail stores and must be special-ordered with costs ranging from $70 to $100, causing only 36% of individuals living in communities most at risk of experiencing gun violence-related trauma to feel able to afford supplies[3,8,9]; and

Table of Contents

Whereas, This barrier in accessing hemorrhage control kits has effectively been targeted with the implementation of community-based kit loaner programs through EMS personnel or hospital- and state-based price locks, which have decreased the cost of purchase to $25 to $50 per kit[9-11]; and

Whereas, There has been an exponential rise in mass casualty events in the United States over the last decade with 9 incidents killing 53 people as of March, 2023 alone[12]; and

Whereas, Of these 9 incidents, the most common locations in order of frequency have been entertainment venues, retail stores, parks, and educational institutions, most of which are not currently required by law to stock hemorrhage control kits due to private ownership[12-18]; and

Whereas, In privately-owned buildings and spaces that had hemorrhage control kits stocked along with traditional first aid supplies, individuals were better able to respond to traumatic events, with one study reporting that 87.7% of employees correctly applied tourniquets and another systematic review highlighting that 40% of victims benefited from the intervention[19-20]; and

Whereas, Due to the unpredictable nature of hemorrhage-related trauma and hurdles to feasibility, studies have recommended stocking hemorrhage control kits using a venue capacity-based approach, starting with 20 kits at minimum to effectively initiate life-saving efforts in large public and private spaces, such as entertainment venues and educational institutions[6,16-20]; and

Whereas, There is currently no federal legislation supporting hemorrhage control training and the provision of bleeding control supplies that has been passed into law[13]; and

Whereas, Only five states - Texas, Tennessee, Arkansas, Indiana, and California - have passed legislation to install hemorrhage control kits in public schools, of which California alone included both public and privately-owned buildings and none addressed cost-related constraints[21-25]; and

Whereas, The AMA has policy (H-130.938, H-45.978, H-45.981) supporting increasing access and funding for the widespread placement of similar life-saving measures in the form of automated external defibrillators (AED) and emergency medical kits, even describing in detail which supplies must be included on in-flight kits; and

Whereas, The AMA also has policy (H-130.935) supporting the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings, though it falls short of accounting for private spaces in which hemorrhage may occur and does not address downstream cost-related barriers that impact trauma response; therefore be it

RESOLVED, That our AMA amend the existing policy H-130.935 Support for Hemorrhage Control Training to promote inclusivity by addition as follows

Support for Hemorrhage Control Training, H-130.935

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in public and private schools, places of employment, and public buildings.
4. Our AMA supports the increased availability of bleeding control supplies through a capacity-based approach in large private recreational spaces, including but not limited to entertainment venues, stadiums, and parks, implemented with collaboration from local, community, and state-level stakeholders.
5. Our AMA supports, through local, community, and state-level stakeholders, the implementation of cost-reduction measures including but not limited to price locks and loaner kit programs to increase the affordability and accessibility of bleeding control supplies by the lay public.

Fiscal Note: Minimal

Date Received: 04/10/2023

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25. Emergency response: trauma kits, California State Legislature; 2022.

RELEVANT AMA AND AMA-MSS POLICY

Support for Hemorrhage Control Training H-130.935
1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.
Res 519, A-16; Modified: Res 527, A-19

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.
CCB/CLRPD Rep. 3, A-14 Appended: Res. 211, I-14 Modified: Res. 919, I-15 Appended: Res. 211, I-18.

In-flight Medical Emergencies H-45.978
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure:
(a) rapid 24-hour access to qualified emergency medical personnel on the ground;
(b) at a minimum, voice communication with qualified ground-based emergency personnel;
(c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies;
(d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form;
(e) adequate medical supplies and equipment aboard aircraft;
(f) routine flight crew safety training;
(g) periodic assessment of system quality and effectiveness; and
(h) direct supervision by physicians with appropriate training in emergency and aerospace medicine.
CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation I-14; Reaffirmed in lieu of: Res. 502, A-16; Reaffirmed in lieu of: Res. 516, A-17

Improvement in US Airlines Aircraft Emergency Kits H-45.981
1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will: (a) support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit; (b) encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits; and (c) encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.
Res. 507, A-97; Amended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of: Res. 502, A-16; Appended: Res. 524, A-18; Modified: Res. 508, A-22

Food Allergic Reactions in Schools and Airplanes H-440.884
Our AMA recommends that all:
(1) schools provide increased student and teacher education on the danger of food allergies;
(2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and
(3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use.
Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 80
(A-23)

Introduced by: Abhishek Dharan, Courtney Holbrook, Texas Tech University Health Sciences Center El Paso Paul L Foster School of Medicine; Whitney Stuard, UT Southwestern School of Medicine; Priya Desai, Boston University Chobanian and Avedisian School of Medicine; Krishna Channa, Christian Tallo, Dean Kim, Kaitlyn Petitpas, University of Connecticut; Hannah Ship, University of Miami Leonard M. Miller School of Medicine; Jordan Peyer, UCLA; Syeda Akila Ally, University of Illinois College of Medicine at Chicago; Julia Versel, Loyola University Chicago Stritch School of Medicine; Shaminy Manoranjithan, University of Missouri

Subject: Medical Second Language Training & Certification for Physicians and Trainees

Sponsored by: Region2,Region 3, Region 7, Association of Native American Medical Students, Asian Pacific, American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, There are 6,900 known languages spoken in the world and 350 languages spoken in the United States (U.S.) with Spanish, Chinese, French, Tagalog, and Vietnamese being the most commonly spoken languages in the U.S. other than English[1]; and

Whereas, Over 25 million individuals in the United States have Limited English proficiency (LEP)[2]; and

Whereas, Federal law requires patients with LEP to be provided with a qualified interpreter for all clinical encounters[3]; and

Whereas, Despite this requirement, persistent barriers to communication continue to exist through functional limitations of video or telephone conferencing, inadequate interpreter staffing, and interpretive inaccuracies[4–7]; and

Whereas, Patients with limited English proficiency experience higher rates of medical errors with worse clinical outcomes than English-proficient patients[8]; and

Whereas, Lack of use of professional interpreters for patients with LEP has been associated with significantly longer inpatient length of stay and higher readmission rates[9]; and

Whereas, Studies have shown that patients rate higher satisfaction, technical quality of care, communication, and physician empathy higher among patients who receive care from physicians who speak their language than professional interpreter services[10]; and

Whereas, A recent systematic review including 33 studies concluded that language-concordant care improves patient outcomes[11]; and

Whereas, Studies have reported patient preference for and higher satisfaction with in-person translators in comparison to virtual translated and that utilization of in-person translators conferred shorter wait times, decreased late arrivals and no-show visits, and in turn greater patient adherence and clinical productivity[12]; and

Whereas, If a physician is bilingual, most hospital systems still technically require the use of a medical interpreter for liability purposes[13,14]; and

Whereas, A bilingual physician is not necessarily certified as a translator and in many hospital systems not allowed to practice without official certification[15]; and

Whereas, Professional interpreters result in a significantly lower likelihood of errors of potential consequence than ad hoc and no interpreters[16]; and

Whereas, Courses allowing bilingual medical students to receive training in interpreting techniques and language skills resulted in increased comfort and understanding of interpretation, as well as high ratings of participants by patients and clinicians in real clinical encounters[17,]; and

Whereas, In one study, 84% of bilingual medical students reported being asked to interpret for patients in a clinical setting, of which 53% described incidents during which they felt uncomfortable interpreting[18]; and

Whereas, Only 28% of medical schools offer students enrolled in clerkships training involving a language interpreter[19]; and

Whereas, Several studies have shown that Spanish language training has resulted in residents feeling more prepared to treat Spanish patients, provide culturally appropriate care, and to promote health equity[20,21]; and

Whereas, A cost analysis study of a family medicine residency program has shown that training their interns with varying Spanish fluency including no prior knowledge resulted in significant overall savings across visits during the PGY2 and PGY3 year when the Spanish-speaking patient population was at least 25% of the total patient population[22]; and

Whereas, While the AMA has numerous policies (H160.924, D-385.957, H-385.928, D-385.978 D-90.999, D-300.976) regarding interpretation services; and

Whereas, AMA policy H-295.870 encourages medical schools to offer medical second languages to their students as electives, these electives are often student run and do not generally include language certification which means the skills cannot be used outside from having a better understanding of what is being said through the interpreter[23,24]; and

Whereas, the AMA does not have any similar policy for residents or physicians; therefore be it

RESOLVED, That our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Medical School Language Electives in Medical School Curriculum H-295.870
Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. Res. 304, A-07 Reaffirmed: CME Rep. 01, A-17

Use of Language Interpreters in the Context of the Patient-Physician Relationship H160.924
1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to

provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. 2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments. BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17, Appended: Res 310, A-22

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

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government. Res. 219, I-01 Reaffirmed: BOT Rep 8, I-02 Reaffirmation I-03 Reaffirmed in lieu of Res. 722, A-07Reaffirmation A-09Reaffirmation A-10Reaffirmation A-14

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

Physician Reimbursement for Interpreter Services D-385.946
1. Our AMA will prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services.
2. Our AMA will continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services. Res 201, I-22

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

Interpreters For Physician Visits D-90.999
Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. BOT Rep. 15, I-98 Reaffirmation I-03 Modified: BOT Rep. 28, A-13 Reaffirmation A-14

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

Discrimination Against Physicians by Health Care Plans H-285.985
Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;
(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;
(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;
(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and
(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate. BOT Rep. 18, I-93 Appended by BOT Rep. 28, A-98 Reaffirmation A-99 Reaffirmation A-00 Reaffirmed: BOT Rep. 6, A-10 Reaffirmed in lieu of Res. 110, A-13

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements. BOT Rep. 25, I-01 Reaffirmation I-03 Reaffirmed: Res. 907, I-03 Reaffirmation A-09 Reaffirmation: A-17

Support for Standardized Interpreter Training D-300.976

Our AMA: (1) encourages physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services"; and (2) will work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. Res. 310, A-22

160.017MSS Study of Interpreter Mandate
AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English. (MSS Res 20, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

160.034MSS Improving Language Access for Limited English Proficiency Patients AMA-MSS supports initiatives to educate physicians and medical students on the appropriate use of medical interpreters. (MSS Res 32, I-16) (Reaffirmed: MSS GC Report A, I-21)

160.036MSS Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings
AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, in the stead of patient family members and friends. (MSS Res 06, A-17)

160.042MSS Support for Standardized Interpreter Training
Our AMA-MSS will ask the AMA to: (1) recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments; (2) encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC "Guidelines for Use of Medical Interpreter Services"; and (3) work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 81
(A-23)

Introduced by: Kristofer Jackson, University of Toledo

Subject: Patient Protections for Implantable Medical Devices and Prosthetics

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Implantable devices and prosthetics are a growing field of medicine with device capabilities and complexity increasing with time; and

Whereas, As prosthesis and devices have grown in complexity and utility the ability to remotely monitor and affect them has grown as well[1,2]; and

Whereas, Tech companies including Amazon, mFine, and others have begun to incorporate a subscription based model into many of their healthcare services[3,4,5,6]; and

Whereas, Many medical assistive devices already operate on a subscription based model including hearing aids, medical alert devices, and text-to-speech software[7,8,9]; and

Whereas, Multiple studies have shown that monitoring of implantable cardiac devices can significantly decrease all-cause mortality[10,11,12]; and

Whereas, Remote monitoring is not always fully covered by insurance, which causes increased costs for patients;[6] and

Whereas, Medical device costs and subsequent maintenance and monitoring costs vary based upon the institution responsible for implanting and monitoring the device[5,11]; and

Whereas, It has been shown that implantable medical devices can be activated or deactivated against the patients will[2]; and

Whereas, Patients are often not notified of relevant changes or failures at the companies that maintain and monitor their devices[13]; and

Whereas, Even when aware of an upcoming disruption corporations can struggle to find and administer solutions to easily foreseeable disruptions[14]; and

Whereas, When companies that make and maintain devices and prosthetics fail or close patients are left without maintenance and repair services and with little recourse for adverse events associated with or caused by their devices and/or prosthesis[15];

Whereas, It has been shown that implantable medical devices can be activated or deactivated against the patients will[2]; therefore be it

RESOLVED, That our AMA supports legislation requiring companies to inform patients of business decisions or news that could negatively affect the function, maintenance, and monitoring of their medical devices or prosthesis in a timely manner; and be it further

RESOLVED, That our AMA supports legislation that requires that companies producing implantable devices and prosthetics designate a surrogate in the event a company fails or is unable to provide the necessary monitoring and maintenance services; and be it further

RESOLVED, That our AMA supports legislation requiring transparency for expected medical device and prosthetic repair and maintenance services and their subsequent costs prior to the implantation of a device; and be it further

RESOLVED, That our AMA supports legislation encouraging payers to cover the costs of device maintenance, required upgrades, and remote monitoring of implantable medical devices and prosthesis; and be it further

RESOLVED, That our AMA opposes planned obsolescence, throttling of effectiveness, unnecessary monitoring fees, and all other types of predatory subscription based models for the use of all prosthetics and implantable medical devices; and be it further

RESOLVED, That our AMA amends Resolution D-480.991 “Access to Medical Care” by addition to read as follows:

> **D-480.991 Access to Medical Care**
> Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure <u>as well as its expected maintenance, support, and monitoring fees</u>.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Access to Medical Care D-480.991
Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, our AMA opposes product-claim (DTCA) that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-claim (DTCA) should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in (DTCA), a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in (DTCA) to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all (DTCA) for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors)

run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of (DTCA).
5. That (DTCA) for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on (DTCA) for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with (DTCA).
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of (DTCA), focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
8. That our AMA supports the concept that when companies engage in (DTCA), they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim (DTCA) and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of (DTCA) in the United States to determine the impact of (DTCA) on health outcomes and the public health. If (DTCA) is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase (DTCA) regulation or, if necessary, to prohibit (DTCA) in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
11. That our AMA supports eliminating the costs for (DTCA) of prescription drugs as a deductible business expense for tax purposes.
12. That our AMA continues to monitor (DTCA), including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding (DTCA), as necessary.
13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.

Medical Device Amendments of the FDA H-480.996

(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to:
   a. not interfere with the physician-patient relationship;
   b. not impose regulatory burdens that may discourage creativity and innovation in advancing device technology;
   c. not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators;
   d. not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and
   e. not interfere with patient records' confidentiality.

(2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.

Oppose Local Coverage Determination for Lower Limb Prostheses H-330.882

Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and

(2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients.

1.2.9 Use of Remote Sensing & Monitoring Devices

Sensing and monitoring devices can benefit patients by allowing physicians and other health care professionals to obtain timely information about the patient’s vital signs or health status without requiring an in-person, face-to-face encounter. Implantable devices can also enable physicians to identify patients rapidly and expedite access to patients’ medical records. Devices that transmit patient information wirelessly to remote receiving stations can offer convenience for both patients and physicians, enhance the efficiency and quality of care, and promote increased access to care, but also raise concerns about safety and the confidentiality of patient information.

Individually, physicians who employ remote sensing and monitoring devices in providing patient care should:

(a) Determine whether using one or more such devices is appropriate in light of individual patients’ medical needs and circumstances, including patients’ ability to use the chosen device appropriately.

(b) Explain how the device(s) will be used in the patient’s care and what will be expected of the patient in using the technology, and disclose any limitations, risks, or medical uncertainties associated with the device(s) and data transmission.

(c) Obtain the patient’s or surrogate’s informed consent before implementing the device in treatment.

Collectively, physicians should:

(d) Support research into the safety, efficacy, and possible non-medical uses of remote sensing and monitoring devices, including devices intended to transmit biometric data and implantable radio frequency ID devices.

(e) Advocate for appropriate oversight of remote sensing and monitoring devices.

180.017MSS Increasing Access to Medical Devices for Insulin-Dependent Diabetics
AMA-MSS will ask that our AMA work with relevant stakeholders to encourage the development of plans for inclusion in the Medicare Advantage Value Based Insurance Design Model that reduce copayments/coinsurance for diabetes prevention, medication, supplies, and equipment including pumps and continuous glucose monitors, while adhering to existing AMA policies.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 82
(A-23)

Introduced by: Narmeen Rehman, Lauren Kasmikha, Trisha Gupte, Wayne State University

Subject: Supporting Food is Medicine Programs

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, A lack of access to sufficient and nutritious food is a major determinant in the development and progression of chronic diseases, with nearly half of deaths in cardiometabolic conditions linked to poor diet[1–10]; and

Whereas, As the prevalence of chronic disease rises, the economic burden of chronic disease has correspondingly surged to $3.7 trillion annually from direct (eg: increased hospitalization and prescription drug use) and indirect costs (eg: lost productivity and premature mortality), highlighting the need for scaling up of effective chronic disease management interventions.[11–13]

Whereas, Chronic disease management can be challenging and costly for patients, making adherence to specific dietary recommendations difficult with studies showing that less than 50% of patients adhere to disease-specific dietary regimens, resulting in poorer health and increased acute healthcare utilization.[14–16]

Whereas, A growing body of evidence shows that the delivery of food and nutrition interventions within healthcare settings is highly effective in enhancing disease prevention and management, addressing nutrition insecurity, improving overall health outcomes, and reducing healthcare utilization and associated costs [16–20]; and

Whereas, “Food is Medicine” (FIM) interventions are defined by the Aspen Institute as evidence-based nutrition interventions that extend beyond simply recommending that patients adhere to a healthy diet, by fostering collaboration between food systems stakeholders (such as, community non-profit organizations, food pantries) and the healthcare system to meet the specific nutritional needs of patients with severe health conditions [20–22]; and

Whereas, One example of FIM interventions that are the widely-researched distribution of medically-tailored meals (MTMs) to patients with complex, severe, or chronic illnesses who are unable to purchase groceries or prepare meals, as prescribed by healthcare professionals, designed by Registered Dietitian Nutritionist (RDN), and covered by health plans to meet the specific caloric and nutritional needs of a patient and their conditions [23–25]; and

Whereas, MTM programs have been established for decades, primarily run by non-profit organizations in collaboration with healthcare institutions, with notable examples such as Community Servings, who first distributed MTMs in response to the HIV/AIDS epidemic in 1990 for patients suffering from malnutrition-related complications; after the success of their meal delivery program, they expanded MTM programs to address more chronic conditions (eg: cancer, kidney failure, and diabetes) and now serve over 875,000 meals every year with their MTM model that many healthcare organizations have now adopted[26,27]; and

Whereas, Several pilot studies have shown that FIM programs (including MTM, medically tailored food packages, and produce prescriptions) effectively improve clinical outcomes for a variety of conditions, such as lowering HbA1c levels in patients with Type 2 Diabetes, reducing blood pressure levels in those with Hypertension, improving quality of life for patients with Heart Failure, and enhancing renal function of individuals with Chronic Kidney Disease[18,28–33]; and

Whereas, Studies show MTM initiatives can significantly reduce healthcare utilization and costs for patients with chronic disease, with one study showing patients who received MTMs for 6 months had a 70% decrease in Emergency Department visits and another study showing that patients with Diabetes who received MTMs for 9 months had 49% fewer inpatient admissions and a resultant annual net savings of $9,000 annually [34–36]; and

Whereas, MTM programs can generate substantial healthcare savings, as demonstrated by a study assessing the cost-effectiveness of national MTM coverage for US patients with diet-related illnesses. The analysis found that providing all eligible individuals with MTMs could result in 1.6 million less hospitalizations and save $38.7 billion in healthcare spending in one year alone [37]; and

Whereas, The value of FIM interventions are now being widely recognized evident through recent developments such as the introduction of House Bill 5370, the Medically Tailored Home-Delivered Meals Demonstration Pilot Act of 2021 which will establish a multi-state Medicare pilot program to assess the benefit of MTM coverage; additionally, with the Biden-Harris pledging more than $8 billion to FIM programs and pilot studies, there are many indicators of our nation's growing importance of the role of addressing nutrition in healthcare settings for chronic disease prevention [38,39] ; and

Whereas, Despite the promising results shown in pilot interventions for FIM programs, larger-scale randomized control and implementation studies are needed to develop best practices and address knowledge gaps – including comparing the efficacy of different interventions, determining the optimal duration of intervention, and integration into payer systems; as well as, more qualitative research to better integrate health behavior perspectives into designing effective programs[15]; and

Whereas, The integration of FIM into the healthcare system has the potential to significantly improve chronic disease management and reduce healthcare expenditures on a broader scale; however, sustained support for research is imperative for these programs to be optimal implementation; therefore be it

RESOLVED, That our AMA acknowledges the rising challenge of chronic diseases in the United States, and how nutritional interventions integrated into clinical care can greatly benefit patients with complex, severe, or chronic illnesses; and be it further

RESOLVED, That our AMA supports further research through larger-scale studies that investigate the cost-effectiveness of coverage, delivery, and efficacy of Food is Medicine interventions.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on the premises of hospitals Medical Care Facilities. 2. Our AMA hereby calls on all hospitals Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages. 3. Our AMA hereby calls for hospital Medical Care Facility cafeterias and inpatient meal menus to publish nutritional information.

Healthful Food Options in Health Care Facilities H-150.949
1. Our AMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities.2. Our AMA hereby calls on all health care facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages. 3. Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information.
4. Our AMA will work with relevant stakeholders to define “access to food” for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals.

Payment for Nutrition Support Services H-150.931
Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 83
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Hailey Baker, University of Minnesota Medical School; Katie Wilson, University of Minnesota Medical School; Canaan Hancock, Dell Medical School at UT-Austin; Anna Klunk, Philadelphia College of Osteopathic Medicine, Brianna Baldwin, University of Virginia School of Medicine

Subject: Indian Water Rights

Sponsored by: Region 1, Region 3, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The United States is a signatory of the 2007 United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), a universal framework of minimum standards for the survival, dignity and well-being of Indigenous Peoples[1]; and

Whereas, Article 26 of the UNDRIP states that “Indigenous [P]eoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired”[1]; and

Whereas, Article 26 the UNDRIP further states that “Indigenous [P]eoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired”[1]; and

Whereas, There are known health disparities for Indigenous Peoples in the United States (American Indians and Alaska Natives) linked to water rights and land displacement; and

Whereas, It is estimated that 48% of American Indian/Alaska Native (AI/AN) households on reservations do not have access to clean water or adequate sanitation, which equates to 58 out of 1,000 AI/AN households versus 3 out of 1,000 White households[2,3]; and

Whereas, 31 Alaska Native communities, representing 6% of the Alaska Native population and 13.5% of Alaska Native villages and reservations within Alaska, have no running water or sewage systems[4,5]; and

Whereas, An estimated 6.5% of American Indian homes, on and off reservations, lack adequate water sources and/or sanitation systems versus <1% of the general US population[6]; and

Whereas, In the Navajo Nation, the largest AI/AN Nation in the U.S. by land size, approximately 30% of the population does not have access to clean water, and are 67 times more likely than other Americans to live without running water or a toilet, due to drought, as well as leaching of heavy metals from abandoned mining sites[7,8,9];

Whereas, Lack of access to a safe water supply has been associated with higher infant hospitalization rates for pneumonia and respiratory syncytial virus, as well as higher rates of hospitalizations for skin infections in all ages[10]; and

Whereas, Unsafe water resources have been linked to chronic and disabling health conditions including but not limited to cancer, renal disease, autoimmune conditions, skin conditions, and diabetes[11,12]; and

Whereas, Beyond biological need, water is a key component to Indigenous cultures, whereby water systems determined settlements, traditional ways of knowing, and is used widely in ceremony by many Indigenous Peoples[11,13]; and

Whereas, Water insecurity has been demonstrated to impact physical, cultural, and spiritual well being among tribal communities[11,14]; and

Whereas, Loss of AI/AN culture has been proven to be a risk factor for chronic conditions[15]; and

Whereas, American Indian and Alaska Native households are 19 times more likely than non-Hispanic White households to lack indoor plumbing, regardless of income[2]; and

Whereas, Lack of indoor plumbing was an early correlate of COVID-19 infection among AI/AN people living on reservations[16]; and

Whereas, Only 42 AI/AN Tribes and Villages meet Environmental Protection Agency (EPA)-approved water quality standards[17]; and

Whereas, In communities without running water, water sources, including wells and water stations, can be miles away, requiring transportation to access them, such as four-wheelers, or using sleds or wheelbarrows to haul water[18]; and

Whereas, The physical burden of hauling water is further compounded by the financial burden, whereby the average American spends $600 per acre-foot of water with piped water delivery and Navajo families spend $43,000 per acre-foot of water with hauled water[14]; and

Whereas, Disputes over Indian Water Rights are long-standing, expensive to resolve, and hinder the management of water resources at the local, State and National levels[19]; and

Whereas, The settlement of Indian Water Rights is a process by which the water claims of major water rights holders are settled, providing certainty that improves water resource management[19]; and

Whereas, The Biden-Harris Administration has recognized the importance of increasing Tribal participation in the management and stewardship of federal lands and waters of significance to Tribal Nations[20]; and

Whereas, The Biden-Harris Administration strongly supports positive Indian Water Rights settlements and coordinate the actions of all relevant federal agencies to use their programs, authorities, and resources to support tribal water needs and economic development activities[20]; and

Whereas, The Indian Health Service (IHS), an agency within the United States Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives[21]; and

Whereas, The IHS is divided into 12 geographic service areas, namely Anchorage, Albuquerque, Bemidji, California, Great Plains, Navajo Nation, Nashville, Oklahoma City, Phoenix, Portland, and Tucson[21]; and

Whereas, The IHS, unlike other federal health programs (e.g., Medicare and Medicaid), is responsible for identifying health hazards on Tribal lands, monitoring and investigating environmentally-caused disease and injury, and providing environmental health training, technical assistance and project funding[21]; and

Whereas, The IHS Division of Environmental Health and Division of Sanitation Facilities Construction are primarily responsible for the delivery of environmental engineering services and sanitation facilities to American Indians and Alaska Native Tribes and Villages[22]; and
Whereas, IHS DEH programs have identified five key priority areas, including children's environment, safe drinking water, food safety, vector borne and communicable diseases, and healthy homes[22]; and

Whereas, IHS SFC programs support the cooperative development and construction of safe water, wastewater, and solid waste systems and related facilities for American Indian and Alaska Native Tribes and Villages[22]; and

Whereas, The IHS is allocating $700 million from the Bipartisan Infrastructure Law to support an increasingly long list of backlogged clean water and sanitation system projects throughout American Indian and Alaska Native communities[23]; and

Whereas, These allocations grossly underestimate the documented IHS FY 2022 need for clean water and sanitation systems (16.6% of documented $4.22 billion need).

1. Anchorage Service Area: $2.25 Billion
2. Albuquerque Service Area: $235.91 Million
3. Bemidji Service Area: $98.53 Million
4. Billings Service Area: $61.50 Million
5. California Service Area: $177.51 Million
6. Great Plains Service Area: $383.30 Million
7. Navajo Nation Service Area: $682.16 Million
8. Nashville Service Area: $43.14 Million
9. Oklahoma City Service Area: $117.73 Million
10. Phoenix Service Area: $165.85 Million
11. Portland Service Area: $136.60 Million
12. Tucson Service Area: $12.92 Million; and

Whereas, The IHS estimates that for every $1 spent on water and sewage infrastructure it can save $1.23 in avoided direct healthcare cost from diseases related to lack of access to clean water[23]; and

Whereas, The AMA strongly supports bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further

recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations (H-350.976); and

Whereas, The AMA recommends that all individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the United States, entitled to the same equal rights and privileges as other United States citizens (H-350.976, Adopted 1998); and

Whereas, The United States conferred dual citizenship upon all American Indians and Alaska Natives and their descendants ad infinitum with passage of the Snyder Act of 1924 (dual tribal enrollment and American citizenship); and

Whereas, While the United States does not support a domestic right to water, it is a signatory of international agreements that recognize the human right to water and also has a trust responsibility to promote health and wellness among American Indian and Alaska Native Tribes and Villages[25]; and

Whereas, Winters v. United States ruled that Tribes and their enrolled members have a reserved right to sufficient water access for, but not limited to, residential, economic, and governmental needs[26, 27]; and

Whereas, Indian Water Rights settlements between states, tribes, and the United States (acting as trustee for the tribe) must also be approved by Congress, leading to an unnecessary multi-year delay in authorizing funds, land transfers, and other actions necessary to carry out the settlements[28,29,30]; and

Whereas, It is the sense of the United States Senate and House of Representatives that access to reliable and clean drinking water is critically important to AI/AN health and welfare and that the federal government must provide water access to tribal members and communities[31,32]; and
Whereas, The AMA has never litigated in support of Indian Water Rights nor submitted federal and Congressional correspondence and/or testimony in support of Indian Water Rights; therefore be it

Resolved, That our AMA:

(1) Recognizes access to water as a public health crisis in American Indian and Alaska Native reservations and villages;

(2) Will make it an organizational priority to work with relevant American Indian and Alaska Native stakeholder organizations, Tribal governmental leaders, and Tribal federal relations staff to secure additional resources for American Indian and Alaska Native sanitation, water treatment, and environmental support and health services;

(3) Will work with state medical societies and associations and American Indian and Alaska Native Tribes and Villages to support Indian Water Rights litigation and federal Indian Water Rights legislation.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Safe Drinking Water H-135.928
Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
(3) Informing consumers about the health-risks of partial lead service line replacement;
(4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers;
(6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;

(7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
(8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead;
(9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and
(10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

Universal Access for Essential Public Health Services D-440.924
Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions.

Environmental Health and Safety in Schools H-135.918
Our AMA: (1) supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner; (2) encourages the establishment of a system of governmental oversight, charged with ensuring the regular inspection of schools and identifying shortcomings that might, if left untreated, negatively impact the health of those learning and working in school buildings; (3) supports policies that increase funding for such remediations to take place, especially in vulnerable, resource-limited neighborhoods; and (4) supports continued data collection and reporting on the negative health effects of substandard conditions in schools.

Indian Health Service H-350. 977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that

those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including proThe policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
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(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 84
(A-23)

Introduced by: Maddy Mash, University of Kansas School of Medicine; Samantha Pavlock, Florida State University College of Medicine; Matthew Linz, Rutgers New Jersey Medical School; Avery Gulino, Cooper Medical School at Rowan University; Udit Vyas, Indiana University School of Medicine; Dhruv Puri, University of California, San Diego School of Medicine; Gino Dettorre, Washington University School of Medicine in St. Louis; Kiersten Woodyard De Brito, University of Cincinnati College of Medicine; Elizabeth Chao, Kansas City University College of Osteopathic Medicine; Caroline Sublett, University of Virginia School of Medicine; Elizabeth Darga, Central Michigan University College of Medicine; Kaye Dandrea, University of New England College of Osteopathic Medicine; Frank Zhou, David Geffen School of Medicine at The University of California, Los Angeles; Shaminy Manoranjithan, University of Missouri School of Medicine; Chandana Kulkarni, Burnett School of Medicine at Texas Christian University; Shreya Mandava, University of Virginia School of Medicine; Brandon Parker, Florida State University College of Medicine; Ashlee Sweet, Lincoln Memorial University-DeBusk College of Osteopathic Medicine; Ashwin Varma, The University of Texas Health Science Center at San Antonio; Abhishek Dharan, Paul L. Foster School of Medicine at Texas Tech University Health Sciences Center El Paso

Subject: Improving Pharmaceutical Access and Affordability

Sponsored by: Region 4, Region 6, Region 7

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In 2021, pharmaceutical expenditures in the United States grew 7.7% compared to the previous year, approaching $578 billion, driven by a variety of pharmaceuticals including adalimumab, apixaban, and dulaglutide,[1]; and

Whereas, In 2022, the average price increase for pharmaceuticals was 10%, with some pharmaceutical price increases exceeding 500%[2]; and

Whereas, Even after accounting for rebates and discounts, prescription drug prices in the United States increased roughly twice as much as in 32 comparable countries in 2018[2]; and

Whereas, Biologics are medications used to treat diseases with underlying immune pathogenesis and account for 38-40% of the pharmaceutical expenditure in the United States[3,4]; and

Whereas, The rise in price biologic medications is largely due to the stringent regulations on patents and approvals under the Biologics Price Competition and innovation Act passed in 2007[5]; and

Whereas, In 2022, up to 3.2 million Americans were being treated with biologic medications, with treatments incurring costs averaging $10,000-$40,000 annually, and in some cases, up to $500,000 annually[6,7]; and

Whereas, In 2018 and 2019, nearly 13 million Americans delayed filling or did not fill prescription medications due to cost, demonstrating that high drug costs can present a significant barrier to patient access[8]; and

Whereas, Low-income individuals were up to 2.5 times more likely to experience difficulties acquiring prescription medication due to cost compared to high-income individuals, leading to lower rates of medication adherence[8,9]; and

Whereas, In the United States, up to 25% of low-income patients are non-adherent with medication due to cost-related barriers, and increased costs are a leading cause of patients switching from high cost biologics to alternate therapies[7,10,11]; and

Whereas, There are also significant racial and ethnic disparities in medication access; for instance, among Medicare beneficiaries with chronic diseases, Black and Hispanic patients have significantly higher rates of medication non-adherence than non-Hispanic White patients[12]; and

Whereas, Commercial insurance plans have policies for pharmaceutical coverage called 'Direct Member Reimbursement' plans, in which patients are required to pay the full cost of medications out-of-pocket to the pharmacy and then later submit a claim for reimbursement[13,14]; and

Whereas, High cost drugs covered by Direct Member Reimbursement plans leave patients with a substantial, out-of-pocket cost burden, with newer medications such as biologic injectable therapies, requiring an initial payment upwards of $20,000 per treatment[15,16,17]; and

Whereas, The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for voluntary retirement and health plans for employees in private industry[18]; and

Whereas, In response to the rising burden of out-of-pocket expenditures for employees, research commissioned by the ERISA Industry Committee (ERIC) found that increasing use of biosimilars would have saved employers and their employees up to $1.4 billion for infliximab and filgrastim alone, leading to savings of 12% and 45% per medication, respectively[19]; and

Whereas, TRICARE, the source of health coverage, including prescription drug benefits, for members of the U.S. Military Health System, often used brand-name medications at higher rates than the Veterans Health Administration and other federal purchasers, according to a 2021 report published by the nonpartisan RAND Corporation[20]; and

Whereas, The Affordable Care Act includes a pathway for biosimilar medications licensed by the FDA, but market uptake and adoption of biosimilars has been hindered in the United States by misinformation and knowledge gaps[21]; and

Whereas, The Inflation Reduction Act (IRA) of 2022 introduced out-of-pocket cost price capping of $2,000 per year for Medicare Part D but did not address price capping for Direct Member Reimbursement commercial pharmaceutical and prescription drug insurance[22,23]; and

Whereas, The IRA limits medication price increases to the price of inflation, however this only applies for drugs that have been on the market for at least 11 years[23,24]; and

Whereas, The IRA requires rebates for Medicare Part D from manufacturers if price increases exceed the national inflation rate, but those on commercial insurance (66.5% per 2020, U.S. Census), especially those with Direct Member Reimbursement plans, are still left having to pay these costs up front, which can extend into the thousands, further perpetuating health disparities[2,25]; and

Whereas, Due to eventual reimbursement from insurance, patients with Direct Member Reimbursement plans are considered to have full insurance coverage of their medication, making them ineligible to receive aid from Patient Assistance Program for the initial out-of-pocket cost[26-29]; and

Whereas, Patient Assistance Programs often have yearly maximums such as the Janssen Care Path plan, which has a maximum of $20,000 per year for aid on medications such as Stelara (ustekinumab; list price of $25,497 in March 2022)[16,27]; and

Whereas, Many Patient Assistance Programs require having commercial insurance, excluding those on public insurance, like TRICARE[26-28]; and

Whereas, While there are AMA policies advocating for economic assistance for non-covered medications and the inclusion of out-of-pocket medication expenses in calculating patient contributions toward the Medicare Part D coverage gap (H-125.977) as well as increased funding for federal and state health insurance assistance programs (H-330.870), these policies do not go far enough in addressing the extreme costs of biologics; and

Whereas, The AMA already supports transparent educational resources for patients and families in multiple languages from health care systems and Medicare that can be directly accessed by consumers and families and that address their benefits and out-of-pocket costs, but the AMA does not explicitly provide funding to support funding for federal and state patient and physician education assistance programs (H330.870); and

Whereas, The AMA currently has policy opposing price controls as a means to provide affordable and accessible therapies, instead promoting market-based strategies to accomplish affordability, despite the fact that the market has produced a steadily increasing burden on patients in the biologic marketplace (H-155.962); and

Whereas, While several AMA policies have addressed rising pharmaceutical costs and access to patient assistance programs, existing policies do not address gaps in care specific to the exorbitant costs of biologic drugs (H-110.988, H-110.992); and

Whereas, The AMA supports reduction of the exclusivity period of biologic therapies as a means to help reduce cost and further supports dialogue to encourage “reasonable restraint in the pricing of drugs,” yet the AMA has not developed policies aimed at mitigating the increasing cost of biologic therapies, nor at directly capping the burden placed on patients by the costs of biologic therapy (H-110.987, D-110.993, H-110.998); and

Whereas, The AMA supports studies to determine safety and efficacy of biosimilars and biosimilar interchangeability as a means to reduce the cost of biologics, and further supports the Biologics Price Competition and Innovation Act (BPCIA) as a method of promoting access and safety to

biologics, yet these policies do not directly address the increasing cost of biologics, patient access to the most efficacious therapy, the costs associated with switching therapies, nor the upfront costs incurred by many new biologics under Medicare Part D (H-125.976, H-125.980)[5]; therefore be it

RESOLVED, That our AMA advocates for decreasing out-of-pocket maximums for prescription drugs including immunotherapy treatments, and for medical insurance benefits including but not limited to ERISA, TRICARE, and ACA to decrease the perpetuation of racial and ethnic health disparities; and be it further

RESOLVED, That our AMA advocates for implementing an initial out-of-pocket maximum for Direct Member Reimbursement policies under commercial insurance pharmaceutical plans.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

H-100.964 Drug Issues in Health System Reform
Our AMA:
(1) Consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
(2) Supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
(3) Reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
(4) Supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
(5) Supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
(6a) Encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
(6b) Encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
(6) Reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
(7) Supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.
(8) Opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
(9) Reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound

medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
(10) Reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.
(BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11; Modified: CMS Rep. 1, A-21).

H-110.980 Additional Mechanisms to Address High and Escalating Pharmaceutical Prices

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
   a. The arbitration process should be overseen by objective, independent entities;
   b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
   c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
   d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
   e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
   f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
   g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
   h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
   i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
   a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
   b. The use of any international drug price index or average should preserve patient access to necessary medications;
   c. The use of any international drug price index or average should limit burdens on physician practices; and
   d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

(CMS Rep. 4, 1-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22).

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
    (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

(CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22).

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
(Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18).

H-110.992 Study of Actions to Control Pharmaceutical Costs
Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.
(Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed in lieu of Res. 229, I-14; Reaffirmed: CMS 2, I-15; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CMS Rep. 08, A-19).

D-110.993 Reducing Prescription Drug Prices
Our AMA will:
(1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and
(2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.
(CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14).

H-110.997 Cost of Prescription Drugs
(1) Our AMA supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
(BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99).

H-110.998 Cost of New Prescription Drugs
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.
(Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14).

H-120.975 Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs
Our AMA:
(1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for indigent patients and the development of a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians;
(2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to indigent patients;
(3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications; and
(4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs.
(Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffimed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14).

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

H-125.977 Non-Formulary Medications and the Medicare Part D Coverage Gap
Our AMA will advocate for: (1) the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, after which coverage resumes; and (2) **economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.**

H-125.980 Abbreviated Pathway for Biosimilar Approval
Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that:
1). places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation;
2). includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and
3). includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.
(Res. 220, A-09; Reaffirmation A-11; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14).

D-125.987 Biosimilar Product Naming and Labeling
Our AMA urges the FDA to finalize Guidance on the naming and labeling conventions to be used for biosimilar products, including those that are deemed interchangeable. Any change in current nomenclature rules or standards should be informed by a better and more complete understanding of how such changes, including requiring a unique identifier for biologic USANs would impact prescriber attitudes and patient access, and affect post marketing surveillance. Actions that solely enhance product identification during surveillance but act as barriers to clinical uptake are counterproductive. However, because of unique product attributes, a relatively simple way to identify and track which biosimilar products have been dispensed to individual patients must be established. If unique identifiers for biosimilar USANs are required to support pharmacovigilance, they should be simple and the resulting names should reinforce similarities by using the same root name following standards for nonproprietary names established by the USAN Council.
(CSAPH Rep. 4, A-14).

D-125.989 Substitution of Biosimilar Medicines and Related Medical Products
Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena:
(1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients;
(2) allow substitution when physicians expressly authorize substitution of an interchangeable product;
(3) limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA.
(Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14).

H-155.962 Maximum Allowable Cost of Prescription Medications
Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.
(CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmation: A-17).

RELEVANT AMA MSS POLICY

100.026MSS Caps on Insulin Co-Payments for Patients with Insurance
Our AMA-MSS will ask the AMA to amend existing AMA policy H-110.984, Insulin Affordability, by addition and deletion to read:

H-110.984. Insulin Affordability
Our AMA will:
(1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing market competition and take enforcement actions as appropriate; and
(2) (support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and
(3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin.

(MSS Res. 11, I-20, AMA Res 118, Adopted as Amended, A-22).

100.031MSS Comparative Effectiveness Research
AMA-MSS will ask
(1) that our AMA study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter and
(2) that our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter.
(MSS Res. 035, A-22).

180.022MSS Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use
AMA-MSS will ask that our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to:
(a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and
(b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation.
(MSS Res. 033, A-22).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 85
(A-23)

Introduced by: William Maher, OU-TU School of Community Medicine

Subject: Addressing the Economic Impacts of Industry Involvement in Medical Device Procurement

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, AMA policy D-155.996 states “Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed”; and

Whereas, The current AMA policy outlines principles for support of value-based pricing for pharmaceuticals, but lacks policy on medical devices (H-110.986 “Incorporating Value into Pharmaceutical Pricing”); and

Whereas, Increased costs of medical devices are passed on to private insurers, who then include that cost in premiums and higher out-of-pocket cost sharing thus impacting patients[1]; and

Whereas, In the last 5 years, multiple ethics articles have asked whether the presence of industry representatives in the operating room presents a financial conflict of interest[2–5]; and

Whereas, The presence of industry representatives in the operating room and catheterization laboratories allows for the representative to influence a physicians’ device choice, presenting a challenge to value-based purchasing for medical devices[6]; and

Whereas, There are large variations in cost without clear quality benefits of medical devices between vendors and between medical centers using the same vendor, as illustrated by, a 2016 study that found the cost of a single pedicle screw ranged from $400-$1843 across 6 spinal implant manufacturers[7]; and

Whereas, Many of the instruments that are sterilized and present in routine surgical cases are not necessary, as illustrated by a study that found in non-complex thoracic surgery procedures up to 75% of the surgical tray instruments available for the case can be removed without impact on the surgeon[8]; and

Whereas, A common fallacy is that industry representatives are necessary because the surgeon does not have time to select the appropriate instruments, but an initiative focused on standardization and optimization of orthopedic surgical instrument trays was able to drastically reduce instruments by 3520 instruments (55% reduction) and produce a 20% overall annual cost reduction all without negatively impacting turnover times[9]; and

Whereas, Discontinuation of disposable instruments and standardization of pediatric surgical trays has been found to yield 20% cost saving with no intraoperative complications or perceived safety concerns[10]; and

Whereas, Device representatives are motivated to attend the cases with the highest potential commission, with some device representatives telling surgeons that their presence is not needed for cases with lower commissions, calling into question whether the device representative is needed for the high commission cases either[2]; and

Whereas, A study of coronary stent utilization found that the presence of a company's representative resulted in a higher procedural cost on average due to changes in device utilization[11]; and

Whereas, In response to concerns about increased costs as a result of industry representatives in the cardiac catheterization lab, the Society for Cardiovascular Angiography and Interventions (SCAI) has among its best practices the principle that industry representative "presence in the cardiac catheterization lab without specific purpose, (e.g., to "observe"), is of uncertain appropriateness and is discouraged, as is their presence solely for the purpose to enhance sales relative to competitor products."[12]; and

Whereas, The SCAI is not unique in their interactions with industry representatives compared to other physicians, and thus adoption of similar language highlighting financial conflicts of interest by the AMA in the AMA Code of Ethics would be beneficial for all physicians that interact with industry representatives; and

Whereas, Current AMA ethical guidelines on "Industry Representatives in Clinical Settings" (E-10.6) addresses the concerns of device representative impacting the health and privacy of patients but lacks policy concerning the potential economic conflict of interest that may exist;

Whereas, In the absence of clinical trials or a robust device tracking database, physicians must rely on claims made by industry representatives who are motivated by profits to provide information on comparative effectiveness of their devices[13]; and

Whereas, In a focus group of device representatives, one device representative stated, "There was never a situation when I thought, 'I know this is inferior and I'm going to sell it anyway.' [It was more like] 'I don't think this is any better, but I know it's more expensive, so I'm going to sell it."[13]; and

Whereas, Medical device representatives are instructed to not provide their older models, unless explicitly requested by the physician, but instead to push newer products as better, even when data does not exist that would suggest superiority[2,13]; and

Whereas, The current device approval process incentivizes companies to focus efforts on making small changes to existing devices utilizing the 510 (k) exemption, rather than innovate new devices which carry a much higher regulatory burden under the premarket approval process[13]; and

Whereas, There are instances where such small changes may confer added efficacy to the medical devices, but the current 510 (k) exemption process has no way of ensuring such benefit since there is no requirement for the new device to be tested in human subjects prior to approval[2,13–15]; and

Whereas, By focusing product lines on minor changes to devices under the 510 (k) exemption, the medical device industry has increased the necessity of the presence of industry representatives in the operating room to troubleshoot the new changes to devices[13]; and

Whereas, Approval under the 510 (k) exemption process only requires a device to pass biomechanical tests and be "substantial equivalence" to an already marketed product to be approved[13,14,16]; and

Whereas, Under the 510(k) exemption process a device does not need to pass any clinical trails before it can be used in patients[14,16]; and

Whereas, The 510(k) exemption process allows for a medical device to be approved based on predicate devices that have voluntary recalls against them, potentially propagating those recall issues within the newly approved device[14,17]; and

Whereas, Devices approved under the 510(k) exemption that are based on predicate devices with recalls, are more likely to be recalled themselves[14,17–19]; and

Whereas, The lack of clinical trial requirement under the 510(k) exemption process allows for faulty devices to cause extensive patient harm before they are recalled as seen in the cases of vaginal mesh and laparoscopic power morcellation[18,20]; and

Whereas, The 510(k) exemption is the predominant route used for approval of medical devices with 81% of all general and plastic surgery devices approved over the past two decades utilizing this route[21]; and

Whereas, A device approval process that mirrored the rigor of the drug approval process would address many of the safety concerns of the heavy utilization of the 510(k) exemption[14,18,20]; therefore be it

RESOLVED, That our Council on Ethical and Judicial Affairs consider the impact that industry representative presence in the operating room or catheterization lab has on increased costs and waste; and be it further

RESOLVED, That our AMA urge congress to pass legislation to update the medical device approval process to strengthen the rigor of the 510(k) exemption process to include:

a) The requirement for clinical trials in human subjects
b) Demonstrated improved therapeutic benefit to patients over the predicate devices on which the exemption is based
c) Extension of the requirement that an exemption may not be predicated on a device that has been recalled to include voluntary recalls

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Hospital Policies on Interactions with Industry H-225.948
1. Our AMA encourages all hospitals to adopt policies governing the interaction of hospital personnel--including both employed physicians and independent members of the medical staff, as well as other hospital staff--with pharmaceutical, medical device, and other industry representatives within the hospital setting. Such policies should: (a) be developed through a collaborative effort of the hospital's organized medical staff, administration, and governing body, and approved by the organized medical staff; and (b) be consistent with applicable AMA policy and ethical opinions on the subject of medicine-industry interaction, including but not limited to:
E-1.001 Principles of Medical Ethics
E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter
E-8.03 Conflicts of Interest: Guidelines
E-8.031 Conflicts of Interest: Biomedical Research
E-8.0315 Managing Conflicts of Interest in the Conduct of Clinical Trials
E-8.047 Industry Representatives in Clinical Settings
E-8.06 Prescribing and Dispensing Drugs and Devices
E-8.061 Gifts to Physicians from Industry
E-9.0115 Financial Relationships with Industry in Continuing Medical Education
H-460.981 University-Industry Cooperative Research Ventures.
2. Our AMA will inform the American Hospital Association of the AMA's position on hospital policies governing the interaction of hospital personnel with pharmaceutical, medical device, and other industry representatives within the hospital setting.

10.6 Industry Representatives in Clinical Settings
Representatives of medical device manufacturers can play an important role in patient safety and quality of care by providing information about the proper use of their companies' devices or equipment and by offering technical assistance to physicians. However, allowing industry representative to be present in clinical settings while care is being given also raises concerns. Their presence can raise pose challenges for patient autonomy, privacy, and confidentiality as well as safety and professionalism in care-giving.
Physicians have a responsibility to protect patient interests and thus have a corresponding obligation to exercise good professional judgment in inviting industry representatives into the clinical setting. Physicians should recognize that in this setting appropriately trained industry representatives function as consultants. Participation by industry representatives should not be allowed to substitute for training physicians to use devices and equipment safely themselves.
Physicians who invite industry representatives into the clinical setting should ensure that:
(a) The representative's participation will improve the safety and effectiveness of patient care.
(b) The representative's qualifications to provide the desired assistance have been appropriately screened.

(c) The patient is aware that an industry representative will facilitate care, has been informed about the scope and nature of the representative's role in care, and has agreed to the representative's participation.
(d) The representative understands and is committed to upholding medical standards of respect for patient privacy and confidentiality.
(e) The representative has agreed to abide by the policies of the health care institution governing his or her presence and clinical activities.
f) The representative does not exceed the bounds of his or her training, is adequately supervised, and does not engage in the practice of medicine.
AMA Principles of Medical Ethics: I,IV,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Registry of Implantable Devices H-480.986
It is the policy of the AMA: (1) to support the concept of a computerized national tracking system for long-term implanted devices that pose a significant risk of serious harm or death to patients if they malfunction or fail completely; (2) that such a system include the communication of the potential for malfunction or failures to the attending surgeon or physician and from the physician to the patient; and (3) to work with all involved parties to satisfactorily address this issue.

Food and Drug Administration H-100.980
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;

g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
b. The use of any international drug price index or average should preserve patient access to necessary medications;
c. The use of any international drug price index or average should limit burdens on physician practices; and
d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

9.6.6 Prescribing & Dispensing Drugs & Devices
In keeping with physicians' ethical responsibility to hold the patient's interests as paramount, in their role as prescribers and dispensers of drugs and devices, physicians should:
(a) Prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient.
(b) Dispense drugs in their office practices only if such dispensing primarily benefits the patient.
(c) Avoid direct or indirect influence of financial interests on prescribing decisions by:
(i) declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products, including offers of indemnification;
(ii) respecting the patient's freedom to choose where to fill prescriptions. In general, physicians should not refer patients to a pharmacy the physician owns or operates.
AMA Principles of Medical Ethics: II,III,IV,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Health Care Expenditures D-155.996
1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.
2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 86
(A-23)

Introduced by: Alec Calac, UC San Diego School of Medicine; Hailey Baker, University of Minnesota Medical School; Canaan Hancock, Dell Medical School at UT-Austin; Anna Klunk, Philadelphia College of Osteopathic Medicine, Brianna Baldwin, University of Virginia School of Medicine

Subject: Improving Access to Pediatric Care to Address American Indian / Alaska Native Infant Mortality

Sponsored by: Region 2, Region 3, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Infant mortality is a public health crisis, particularly among American Indian and Alaska Native (AI/AN) children[1]; and

Whereas, The AI/AN infant mortality rate is nearly twice that of non-Hispanic Whites[2]; and

Whereas, Since 2005, the infant mortality rate has declined for all racial and ethnic groups, except for AI/AN infants, who remained at 7.5 deaths per 1,000 live births[3]; and

Whereas, Continued elevation of AI/AN infant mortality rates suggests that AI/AN infants have not benefited from advances that have reduced infant mortality rates in non-AI/AN populations indicating a need for more targeted intervention[4]; and

Whereas, The leading causes of death for AI/AN infants are complications of congenital malformation, Sudden Infant Death Syndrome (SIDS) and unintentional injury (e.g., automobile accidents)[2,5]; and

Whereas, Many of the leading causes of death for AI/AN infants are preventable through routine pediatric primary care visits in the first year of life[2,5,6]; and

Whereas, Pediatric encounters provide an opportunity for maternal education and support for healthy infant sleep habits to prevent SIDS and vaccinations to decrease the risks of preventable infectious diseases[5]; and

Whereas, Pediatricians and pediatric nurse practitioners represent only about eight percent of IHS providers[5]; and

Whereas, Many AI/AN infants and children do not have access to IHS clinics and must be seen at non-IHS or tribally-affiliated clinics[7]; and

Whereas, Since 2003, the Eunice Kennedy Shriver National Institute of Child Health and Human Development has worked with tribal leaders, organizations, and the Indian Health Service to coordinate the Healthy Native Babies Project, which has gathered evidence for helping AI/AN

infants sleep safely, modeled strategies for teaching safe AI/AN infant sleep to parents and guardians[8]; and

Whereas, The Healthy Native Babies Project follows a landmark study of AI/AN parents and guardians living in the Northern Plains, which identified behaviors that positively and negatively influence SIDS risk: and

Whereas, The Aberdeen Area Infant Mortality Study found that AI/AN infants were 80 percent less likely to die of Sudden Infant Death Syndrome (SIDS) if their mothers received visits from public health nurses before and after giving birth[9,10]; and

Whereas, The Healthy Native Babies Project was preceded by multiple working group and focus group meetings involving AI/AN stakeholders and federal partners, as well as tribal elders and public health experts, to develop a comprehensive approach for how to best reach AI/AN audiences with safe sleep messages[8]; and

Whereas, The resulting approach, informed by the Aberdeen Area Infant Mortality Study and Healthy Native Babies Project, has focused on culturally appropriate outreach using community-tailored resources, resource stipends, training sessions, and technical assistance[8]; and

Whereas, The American Academy of Pediatrics recommends providers promote evidence-based supports for parents and young children by promoting the use of home visiting models, high-quality child care, and early childhood programs[7]; and

Whereas, The AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs (H-350.976); and

Whereas, The AMA recognizes the importance of studies that prioritize the AI/AN population and close evidence gaps in the literature (D-460.969, D-350.985, H-350.976); therefore be it

RESOLVED, The AMA will collaborate with the American Academy of Pediatrics in their efforts to increase the use of evidence-based supports for AI/AN parents and young children by promoting the use of home visiting models, high-quality child care, and comprehensive pediatric care; and be it further

RESOLVED, The AMA will collaborate with the Indian Health Service, Center for Medicare and Medicaid Services, Tribal authorities, state public health agencies, and relevant community organizations to increase the distribution of appropriate American Indian and Alaska Native (AI/AN) infant health and safe parenting materials in the spirit of self-determination to reduce infant mortality and improve overall health outcomes of AI/AN children.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Infant Mortality D-245.994

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.

2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

Infant Mortality Statistics H-245.998

The AMA (1) requests that all countries use a standard form of reporting births in their country and the deaths that result per 1,000 live births based on rules and regulations set up by the World Health Organization; and (2) supports publicizing that the medical profession is vitally concerned with infant mortality rates and pledges to continue its efforts to decrease the infant mortality rates in the US to the lowest rate possible.

Perinatal and Infant Mortality Reviews H-245.992

Our AMA join with ACOG and the American Academy of Pediatrics in calling for a national effort to provide guidance for local perinatal and infant mortality reviews, to stimulate implementation of these reviews at state and local levels, and to encourage state and county medical societies to support these efforts locally.

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

Access to Primary Care Services H-160.951

The AMA (1) will work to assure that a patient's access to primary and principal care services provided by a physician is not limited by the specialty or subspecialty designation of the physician, but should be determined by the training, competence, and experience of the physician to provide primary or principal care services; (2) urges health plans to allow physicians with the appropriate qualifications to elect to provide primary, specialty and subspecialty care services, and to pay these physicians appropriately for the provision of such services; (3) encourages all health insurance programs, indemnity programs, HMOs and federally funded health insurance programs, such as Medicare and Medicaid, to list Med-Peds physicians who request dual listings, to include them as both adult and pediatric clinicians, and (4) urges physicians, prior to electing to provide both primary and specialty care services under a specified health plan contract, to consider the possible economic and profiling consequences of such actions.

Infant Mortality in the United States H-245.986

It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 87
(A-23)

Introduced by: Nuala Keany, Long School of Medicine

Subject: Sleep Physiology and Wellness in Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Sleep is necessary for normal immune system function[1]; and

Whereas, Sleep is necessary for cardiovascular and metabolic health[2,3,5]; and

Whereas, Sleep is necessary for executive functioning and memory consolidation[2,5]; and

Whereas, Sleep and its sequelae are controlled by the interaction between circadian rhythm and sleep-wake homeostatic drive[1,5]; and

Whereas, Sleep deprivation increases symptoms of anxiety and depression[7]; and

Whereas, Medical students experience higher rates of sleep disturbances than the general population[5]; and

Whereas, Medical trainees receive little to no formal education on sleep or factors influencing the quality of sleep[5,10]; and

Whereas, Medical students struggle to translate factual knowledge about sleep into strategies to improve their quality and quantity of sleep[8]; and

Whereas, Students report lower quality of life and higher anxiety with increased daytime sleepiness [4,6-7]; therefore be it

RESOLVED, That our AMA recognizes sleep as foundational to health and well-being; and be it further

RESOLVED, That our AMA supports curriculum coverage of sleep physiology to include the interaction between circadian rhythm and sleep-wake homeostatic drive; and be it further

RESOLVED, That our AMA encourages wellness resources to include strategies for medical trainees to improve their quality and quantity of sleep.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Medical Education on Sleep and Sleep Disorders H-295.894
Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. Res 310, I-98

Insufficient Sleep in Adolescents H-60.930
1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.

2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times

to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.
Res 503, A-10; Appended: Res 404, A-15

Promoting Fitness and Healthy Lifestyles 440.021MSS
AMA-MSS encourage all physicians and health professionals to set an example by (1) striving to maintain a healthy weight and engaging in physical activity as recommended by scientific literature and expert panels; (2) maintaining a healthy and nutritious diet as recommended by scientific literature and expert panels; and
(3) getting enough sleep to avoid the known short and long term adverse effects of sleep deprivation as recommended by scientific literature and expert panels. MSS Res 28, I-04

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 88
(A-23)

Introduced by: Sophia Doerr, Jared Boyce, Laurie Lapp, University of Wisconsin School of Medicine and Public Health; Christian Tallo, Jessica Macintyre, University of Connecticut School of Medicine

Subject: Family and Intimate Partner Violence and Abuse

Sponsored by:

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The CDC estimates that nearly half of women (48.4%) in the United States have experienced some form of emotional abuse or coercive control during their lifetime, at instances higher than physical or sexual abuse (35.6%) however the impacts of emotional abuse are downplayed in the United States;[1-3] and

Whereas, Emotional abuse has been demonstrated to cause post-traumatic stress disorder (PTSD) and other related disorders at rates similar or higher than physical or sexual abuse, with a systematic review finding that the occurrence of psychological abuse was a key predictor of PTSD symptomatology;[4-6] and

Whereas, The sequelae of emotional abuse have significant impacts ranging from negative individual health outcomes to societal costs such as increased rates of joint disease, asthma, activity limitations, HIV risk factors, current smoking, alcohol use, missed or deferred routine primary care, loss in productivity, and an estimated $124,300 and $28,000 per-person lifetime cost for victims who identified as female and male (in 2023 dollars), respectively;[7,8] and

Whereas, Rates of IPV including emotional abuse have been demonstrated to be higher in minoritized groups including racial and ethnic minorities, LGBTQ+, and transgender youth and adults, with transgender and Black individuals experiencing the highest rates as compared to other demographics at 1.7 and 1.3 times higher than cisgender and white individuals, respectively;[5,6,9,10] and

Whereas, The term IPV has not historically included emotional abuse, a bias which even appears in some contemporary research, and our AMA's existing Policy H-515.965, which encompasses AMA's stance in advocacy towards treatment and prevention of IPV, does not explicitly define the term to include emotional abuse;[6,11] and

Whereas, A limited definition of IPV essentializes physical and sexual violence in medical discourse and diagnosis, and biases research towards physical and sexual violence treatment and prevention, each at the expense of psychological safety, holistic approaches to treatment, and primary prevention interventions and research relating to the much broader class of abuse that an inclusive definition encompasses;[1] and

Whereas, Emotional abuse is a serious, distinct, and often ignored form of IPV which is further excluded and even stigmatized by the limited notion of violence, a reductive term which ignores the complexities of abuse and commonly colors interactions survivors have with others regarding their experiences;[12] and

Whereas, Emotional abuse is downplayed in our society, pivotally so within the contexts of law and medicine, where emotional abuse is not recognized as a criminal or civil offense, generally cannot be used as evidence towards a restraining or protective order, and is historically relegated in favor of definitions which prioritize physical and sexual violence;[6,13,14] and

Whereas, Emotional abuse as a form of IPV has similar or worse impacts on survivors, and survivors of both emotional and physical abuse reporting that damage to sense of self and psyche is worse for emotional abuse than for physical abuse;[15-17] and

Whereas, Healthcare providers and others misunderstanding, ignoring, or invalidating a survivor's experiences, such as inquiring exclusively about physical safety, is shown to have adverse health and treatment outcomes including worsening psychological safety, PTSD symptomatology, depression, anxiety, and staying in an abusive relationship, where survivors experienced invalidating social reactions around 58% of the time when disclosing their experiences;[18-24] and

Whereas, There is a gap in existing research on the complexities and impacts of emotional abuse in all of its forms including the coercive control mechanisms of victim blaming and gaslighting;[25] and

Whereas, Recognition of emotional abuse has been accepted and encoded in policy within healthcare specialty organizations, while the AMA has not yet adopted this evidence-based language in their current policies;[26,27] and

Whereas, Amended language within AMA Policy H-515.965 is needed to explicitly define IPV inclusive of emotional abuse to guide medical discourse, practice, and research towards a more effective and holistic response to what that policy already recognizes is "a major public health issue;" and

Whereas, Our AMA recognizes the importance of treating survivors of IPV, but does not yet recognize evidence-based primary prevention interventions to diagnose and treat perpetrators, to stop cycles of abuse before they begin, nor to educate patients on relationship health as a strategy to prevent future incidents of IPV;[28-32] and

Whereas, Primary prevention of IPV definitionally necessitates intervention at the sources of abuse, namely, current and future perpetrators of abusive behavior;[28-32] and

Whereas, Evidence demonstrates that certain personality disorders and other mental health conditions correlate with perpetration of IPV and are clinically relevant as diagnostic risk factors for perpetration of IPV;[33,34] and

Whereas, The Community Preventive Services Task Force, an independent panel of experts that develops evidence-based recommendations based on rigorous systematic reviews, recommend primary prevention programs that target perpetrators in reducing prevalence and

severity of IPV, improving emotional and relationship health, and increasing safety-promoting behaviors;[28-30] and

Whereas, Effective interventions and resources found in systematic reviews and other evidence include direct diagnosis and treatment of personality disorders correlated with abusive behavior, youth-focused relationship and emotional health education, couples-focused interventions, and male identity groups;[29,31,32,35-37] and

Whereas, There are promising benefits to primary prevention programs, however, methodological limitations in the existing literature indicate a need for further research into effective primary prevention interventions;[28,31,38] and

Whereas, Existing AMA Policy H-515.965 provides only passing mention of prevention and largely defers responsibility for prevention to criminal justice, social support, and community organizations; and

Whereas, Given evidence supporting primary IPV prevention beyond the limited scope of substance use disorder interventions, our AMA Policy must further be amended to directly encode and encourage evidence-based primary prevention methodologies and further prevention research; and therefore be it

RESOLVED, That our AMA amends Family and Intimate Partner Violence, H-515.965 by addition and deletion to include explicit mentions to emotional abuse as a form of intimate partner violence (IPV), the explicit identification, diagnosis, and treatment of perpetrators of IPV, including primary prevention strategies, and further research on emotional abuse, and IPV primary prevention strategies, as follows:

> (1) Our AMA believes that all forms of family and intimate partner violence (IPV) including emotional abuse, sexual abuse, and physical abuse, are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and abuse 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 abuse, and remains open to working with all interested parties to address violence and abuse 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~~ abuse including emotional, sexual, and physical abuse 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 abuse and violence, and elder abuse, and provide training on interviewing techniques, ~~risk~~ assessment for those at risk of perpetrating or experiencing IPV, relationship health education for all patients, safety planning for those at risk of violence, the intersection of IPV risk

factors with marginalized identity, and procedures to connect ~~for linking with resources to assist~~ survivors and abusers with resources appropriate to each. Our AMA supports the inclusion of questions on family violence issues, including all forms of abuse, on licensure and certification tests.

(3) The prevalence of family violence and abuse is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors and perpetrators 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 relationship health and family ~~violence~~ abuse histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse ~~or threats~~ from intimate partners, assess and discuss safety issues with the patient before ~~he or she~~ they leave~~s~~ 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) Upon identifying patients at risk of perpetrating violence or abuse towards intimate partners, educate the patient on healthy relationships and the lifelong impacts that these behaviors can have on those around them, and refer and strongly encourage the patient to join community primary prevention programs; (~~c~~d) After diagnosing an abuse~~violence~~-related problem, ensure to educate the patient about the spectrum of abuse including emotional abuse, and refer patients to appropriate medical or health care professionals and/or community-based trauma-~~specific~~informed resources as soon as possible; (~~d~~e) ~~Have~~Keep and maintain written lists of resources available for survivors of violence and abuse, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid**,** as well as resources to educate and empower survivors; (~~e~~f) Screen patients for psychiatric sequelae of trauma caused by violence or abuse and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence and abuse; (~~f~~g) ~~Become aware of~~Seek out local resources and referral sources that have expertise in dealing with trauma from IPV; (~~g~~h) 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~~i) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (~~i~~j) Record a patient's IPV history, observed trauma potentially linked to IPV, and referrals made; (~~j~~k) Become actively involved in appropriate local programs designed to prevent violence and abuse 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 partner violence and preventative health education for all patients at risk of perpetrating violence and abuse. 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.(d) Believes it is critically important to recognize emotional abuse as a more pervasive and common form of IPV than physical or sexual abuse, and to promote research to better understand emotional abuse, its prevention, and its impacts on the mental health of patients.
(e) Believes it is critically important to pursue research to deepen our understanding of the psychological and behavioral risk factors and sequelae associated with perpetration of violence and abuse in addition to primary prevention already mentioned in policy.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS 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.

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS
AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 89
(A-23)

Introduced by: Shriya Veluri, University of Texas Health Science Center at San Antonio

Subject: Promoting Mobile Mammography Units in Medically Underserved Regions

Sponsored by: Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer deaths in women in the United States[1]; and

Whereas, In 2021, over 281,000 women were diagnosed with breast cancer and over 44,000 died from this disease[1]; and

Whereas, The American College of Radiology (ACR) and The Society of Breast Imaging recommend annual screening mammography for women 40 years and older[2]; and

Whereas, Regular mammography screenings can detect breast cancers at early stages, when interventions are more effective and prognoses are better[3]; and

Whereas, Mammography screening results in a 41% reduction in mortality and a 25% reduction in the incidence of advanced-stage breast cancers[4]; and

Whereas, Individuals who undergo mammography screening infrequently (once every two years) or not at all are more likely to be diagnosed with more advanced stage breast cancer, which is associated with poor clinical outcomes[3]; and

Whereas, Lack of participation in screening mammography is linked to social determinants of health such as lower education and income levels, lack of transportation, less access to care, and less expensive housing[5]; and

Whereas, Low-income individuals from racial or ethnic minority groups are 30% more likely to be diagnosed with late-stage breast cancer than higher-income individuals from racial or ethnic minority group, due in part to low rates of screening mammography and poor access to care[6]; and

Whereas, Mobile mammography units (MMUs) are vehicles that contain mammography equipment that can be driven to various locations, and they have been widely successful in increasing breast cancer screening adherence[7]; and

Whereas, MMUs are equipped with high-quality technology and staffed by board-certified technologists and interpreting physicians in accordance with ACR accreditation guidelines[8]; and

Whereas, MMUs are a crucial source of patient education regarding the breast cancer screening guidelines, general breast health and care, and interpretation of mammography results, especially for patients who do not have a primary care physician[9]; and

Whereas, The patient population of MMUs primarily consists of individuals from low-income and/or racial or ethnic minority backgrounds, with over 55% of patients being uninsured and 71% of patients identifying as a racial or ethnic minority as compared to 15% at traditional breast cancer screening facilities[9]; and

Whereas, MMUs reduce geographic and socioeconomic disparities in breast cancer screening with a gain in participation among women living in areas more than 15 kilometers from a breast cancer screening facility[10]; and

Whereas, MMUs had a recall rate of 7% and a cancer detection rate of 4.5 per 1000 mammograms, which align with optimal recall and early breast cancer detection rate recommendations[11,12]; and

Whereas, One MMU intervention helped avoid nearly 1.2 million dollars in healthcare costs by decreasing emergency department visits from breast cancer complications by more than 1100 visits over the span of four years[9]; and

Whereas, The cost-effectiveness of MMUs increased significantly for individuals living in areas more than 15 kilometers from a breast cancer screening facility[10]; and

Whereas, Despite low accessibility to mammographic facilities in rural and medically underserved regions, MMUs were suboptimally dispatched to these locations, considering that MMUs were only dispatched 23% of days within the study window[13]; and

Whereas, MMUs consistently reach more urban than rural patients and locations[14]; therefore be it

RESOLVED, That our AMA promote mobile mammography units to screen eligible individuals for breast cancer in under-resourced regions, including but not limited to rural areas, medically underserved areas, and regions with limited mammography facilities, in order to address socioeconomic and geographic disparities in breast cancer screening; and be it further

RESOLVED, That our AMA encourage the identification of optimal locations for mobile mammography units to increase access to breast cancer screening in under-resourced regions.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Guidelines and Medicare Coverage for Screening Mammography, H-525.986
Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age.
BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep.1, A-11; Reaffirmed: CSAPH Rep.1, A-21

Screening Mammography, H-525.993
Our AMA:
a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.
d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. supports insurance coverage for screening mammography.
i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.
CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12; Reaffirmed: Alt. Res. 803, I-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 90
(A-23)

Introduced by: Jared Boyce, Sophia Doerr, Laurie Lapp, Kristin Kohlmann, University of Wisconsin School of Medicine and Public Health; Yuan Xie, Kansas City University College of Osteopathic Medicine; Gautami Galpalli, Southern Illinois University School of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Nawara Abufares, Medical College of Wisconsin; Ana Sofía Velázquez López, Ponce Health Sciences University School of Medicine; Kikelola Afolabi-Brown, Rutgers Robert Wood Johnson Medical School

Subject: Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers

Sponsored by: Region 2, Region 6, Student Osteopathic Medical Association, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, In 2022, over 100 million people were forcibly displaced globally and the United States of America resettled 25,465 refugees[1,2]; and

Whereas, Asylum seekers are people fleeing conflict, violence, human rights violations, extreme poverty, or persecution, whose request for sanctuary in the current country they are located in is not processed[1] or approved yet[1,3]; and

Whereas, For the 2023 fiscal year, there is a backlog of 787,822 asylum cases in the United States, and projections predict the 2023 backlog to grow to over 180,000[4]; and

Whereas, Given the current backlog of asylum cases, there is an urgency for more physicians trained in conducting forensic medical evaluations, immigration lawyers, and affordable access to these resources for asylum seekers[4,5]; and

Whereas, A lengthy and traumatic migration and asylum application process can harm children and adolescents, including Resignation Syndrome, a comatose-like state that is typically alleviated after being granted asylum[6,7,8]; and

Whereas, Forensic medical evaluation for asylum seekers is the process of documenting a history of trauma, physical and psychological evidence of abuse, and assessing the degree of consistency between examination findings and specific allegations of abuse by the applicant[9]; and

Whereas, The purpose of a forensic medical evaluation is not to provide medical treatment to asylum seekers, but to identify and record findings that support or refute the asylum seeker's

history of persecution, harm, trauma, and risks associated with returning to their home country[2]; and

Whereas, The physical manifestations of maltreatment include broken bones, burns and scars, and neurological damage, and the psychological and emotional signs of maltreatment include depression, flashbacks, fatigue, posttraumatic stress disorder, and memory disturbances[10,11]; and

Whereas, Physicians play a critical role in the asylum evaluation process by providing evidence for immigration judges to "base decisions regarding a well-founded fear of persecution"[12]; and

Whereas, 42% of those seeking asylum are unrepresented in the Court's records and unrepresented asylum seekers were granted asylum 17.7% of the time while those that were represented were granted asylum 31.1%[4,8] of the time; and

Whereas, Forensic medical evaluations conducted by physicians have been demonstrated to improve asylum grant rates, 73.7% of the positive cases were asylum grants compared to 42.4% of asylum seekers nationally[13]; and

Whereas, The demand for forensic medical evaluations exceeds the 2,000 physicians trained by Physicians for Human Rights to conduct them, leading to a need for more physicians trained in forensic medical evaluations[13,14]; and

Whereas, There is a role for physicians from a variety of medical specialties to conduct forensic medical, gynecological, and psychological evaluations; including psychiatrists familiar with working with survivors of torture and pediatricians trained to conduct evaluations in both accompanied and unaccompanied children seeking asylum[14,15]; and

Whereas, The Asylum Medicine Training Initiative offers standardized training for any physicians in forensic medical evaluations and is free, self-paced, and takes 5-7 hours to complete[16]; and

Whereas, Student-run asylum clinics demonstrate success both in completing forensic medical evaluations which result in successful asylum cases and in training more than 1,400 physicians to complete asylum evaluations[17,18,19]; and

Whereas, According to the U.S. Law, an asylum seeker is granted asylum if they are credible, persuasive, and have strong testimony[20]; and

Whereas, Successfully being granted asylum in the United States of America resulted in a reduction in depression, anxiety, and post-traumatic stress disorder post-migration[21,22]; and

Whereas, For the 2023 Fiscal Year, 18.3% of asylum seekers without legal representation were granted asylum while 48.9% of asylum seekers with legal representation were granted asylum[23]; and

Whereas, Without legal representation, asylum seekers are more likely to be denied asylum and subsequently experience worse health outcomes[21,22,23]; and

Whereas, Only 18% of states have statewide publicly funded legal universal representation, meaning that all asylum seekers in the state receive legal representation[24]; therefore be it

RESOLVED, That our AMA supports efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative; and be it further

RESOLVED, That our AMA encourages individual and collective physician collaboration with legal organizations to increase access to medical and psychiatric forensic evaluations and legal representation for asylum seekers; and be it further

RESOLVED, That our AMA supports further study of the mental and medical health outcomes of asylees pre- and post-asylum determination with relevant stakeholders including but not limited to the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Legal Medicine, and American Academy of Psychiatry and the Law.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Improving Medical Care in Immigrant Detention Centers D-350.983

1. Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

2. This policy shows that the AMA has advocated for health care for immigrant detention centers, which is favorable for your resolves.

Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women D-345.982

Our AMA will advocate for: (1) increased research funding to evaluate the validity, efficacy, and implementation challenges of existing mental health screening tools for refugee and migrant populations and, if necessary, create brief, accessible, clinically-validated, culturally-sensitive, and patient centered mental health screening tools for refugee and migrant

populations; (2) increased funding for more research on evidence-based mental health services to refugees and migrant populations and the sex and gender factors that could increase the risk for mental disorders in refugee women and girls who experience sexual violence; (3) increased mental health training support and service delivery funding to increase the number of trained mental health providers to carry out mental health screenings and treatment; (4) and encourage culturally responsive mental health counseling specifically.

Immigration Status is a Public Health Issue D-350.975

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.

2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.

3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.

4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

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.

Relevant AMA Correspondences

Comment Letter to DOJ: comment on the Procedures for Credible Fear Screening and Consideration of Asylum, withholding of Removal, and Convention Against Torture Protection Claims by Asylum Officers proposed rule

- **Page 2:** "Given the heightened number of individuals seeking sanctuary in the United States, **we believe that the problems and backlogs the immigration system faces will only grow, underscoring the need for near-term systemic changes.** We believe that the changes in the proposed rule concerning the expanded power of asylum officers, increased use of parole in the immigration system, and increased funding will improve how the immigration system functions and reduce cases like that of Omar Abdulkarim Qanat and Fadhila Mustafa Yosof, who fled Libya in the wake of the collapse of the Gaddafi regime and recently filed a suit in federal court requesting that the federal government schedule an asylum interview for them after having "been irreparably damaged from the fear of not knowing what will happen with their asylum case for the past five years...."2 Unfortunately, these cases are not unusual, and are representative of the hundreds of thousands of asylum cases pending before U.S. Citizenship and Immigration Services (USCIS)." **Pages 3-4: "For these determinations by asylum officers to be accurate, it is essential that asylum officers have the proper training to elicit all the necessary information to make an informed decision especially given the fact that the United States Commission on International Religious Freedom (USCIRF) has found, since 2005, that "DHS officials often fail to follow required procedures to identify asylum seekers and refer them for credible fear determinations…" 1"**

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 91
(A-23)

Introduced by: Ida Vaziri, UT Health San Antonio Long School of Medicine; Shaminy Manoranjithan, University of Missouri Columbia School of Medicine; Sarah Mae Smith, University of California Irvine School of Medicine; Rajadhar Reddy, Baylor College of Medicine

Subject: Humanitarian Efforts to Resettle Refugees

Sponsored by: Student Osteopathic Medical Association

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

Whereas, The United Nations Convention relating to the Status of Refugees, also known as the 1951 Convention, defined refugee as “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” and defined the legal obligation of States to protect them[1]; and

Whereas, Section 101(a)(42) of the Immigration and Nationality Act defines “refugee” as an individual who has experienced past persecution or has a well-founded fear of persecution on account of their race, religion, nationality, membership in a particular social group, or political opinion[2,3]; and

Whereas, Contracting States a part of the 1951 Convention agree to cooperate with the United Nations High Commissioner for Refugees (UNHCR) to adopt laws and regulations to ensure application of this convention[1]; and

Whereas, The actual number of refugees admitted to the United States was lower than the refugee admissions ceilings for Fiscal Year 2002 to Fiscal Year 2013 leading to anywhere from 5,000 to 40,000 refugees unallocated[4]; and

Whereas, UNHCR expects an estimated 117.2 million forcibly displaced people globally in 2023, of which 29.3 million are refugees, half of which are children, and 74% of which are hosted in low or middle income countries; this is the highest number on record displaced[5]; and

Whereas, Over a 20-year period, it is estimated that refugees who enter the United States between age 18-45 pay on average $21,000- $43,707 more in taxes than they receive in benefits[7,8]; and

Whereas, Refugees contributed an estimated $20.9 billion in taxes to the United States in 2015[10]; and

Whereas, It is estimated that refugees in Akron, Ohio paid over $3 million in state and local taxes, in addition to contributing $3.6 million to Social Security and over $840,000 to Medicare[9]; and

Whereas, Refugees were responsible for producing billions of dollars in annual economic activity and creating thousands of jobs in Southeastern Michigan, Minneapolis, and Ohio [9,11]; and

Whereas, Recent estimates have indicated that 20.3% of the population of the United States will be older than 65 years of age by 2030, and that refugees can help offset the cost of our aging population on Medicare[13]; and

Whereas, An estimated 77.1% of refugees are working age, as opposed to the 39.7% of the US-born population[12]; and

Whereas, Male refugees participate in the labor force as high or higher than their native-born counterparts[7,14]; and

Whereas, It has been estimated that fewer than 3% of refugees return to their country of origin[6]; and

Whereas, More than 84% of refugees who have been in the country for 16 to 25 years have taken steps to become citizens, compared to roughly half of all immigrants across the same span[10,15]; and

Whereas, Annual U.S. refugee arrival fell by 86% between Fiscal Years 2016-2020, leading to a roughly 295,000 person gap estimated to cost the economy over $9.1 billion each year[8]; and

Whereas, Forced displacement results in unique health disorders with long-lasting impact that can affect multiple generations[16]; and

Whereas, Restrictions on refugee admissions has a significant impact on mental health, including exacerbation of depression, post-traumatic stress disorder, anxiety, and somatization[16]; and

Whereas, Decreased resettlement caps and worsening backlogs have delayed family reunification, a significant stressor contributing to adverse mental health effects among resettled refugees[16]; and

Whereas, Once people are displaced from their countries of origin, they are often displaced for decades and have very few options other than resettlement, remaining indefinitely in refugee camps, or living under the radar and/or undocumented[17]; and

Whereas, This prolonged displacement results in often otherwise preventable medical issues that remain neglected until they are more severe, less treatable, and more costly to the individual and to the healthcare system[17]; and

Whereas, Refugees may be accepted into the United States more rapidly if they are more medically-complex and vulnerable, in order to connect them with life-saving medical care[18]; and

Whereas, Efforts to decrease refugee admissions put such individuals at risk for life-threatening complications[19]; and

Whereas, Opposing restrictions and supporting increases in refugee caps allows refugees to access resources provided to them by the State, including healthcare[19]; and

Whereas, As outlined in AMA Policy H-350.957 (Addressing Immigrant Health Disparities), our AMA advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees; therefore be it

RESOLVED, That our AMA support increases and oppose decreases to the annual refugee admissions cap in the United States.

Fiscal Note: Minimal

Date Received: 04/10/2023

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RELEVANT AMA AND AMA-MSS POLICY

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Res. 006, A-17

Humanitarian and Medical Aid Support to Ukraine D-65.984
Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people.
Res. 017, A-22

Status of Immigration Laws, Rules, and Legislation during National Crises 350.027MSS
“In order to recognize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic, our AMA- MSS will ask our AMA to: (1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; (2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; (3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and (4) oppose utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution.” (MSS Res. 013, Nov.

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A
(A-23)

Introduced by: Reilly Bealer, Chair

Subject: Policy Sunset Report for AMA-MSS Policies

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 1995 National Medical Student Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-95 and reaffirmed by MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including:

- To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
- To assist in the identification of areas where additional policy is needed;
- To help identify and remove outmoded, duplicative, or inconsistent policies;
- To promote efficiency in Assembly deliberations; and
- To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044MSS. At the 2022 Annual Meeting, the assembly voted to amend this policy to allow for referral of policies proposed to be sunset, ensure that feedback is solicited from relevant Standing Committees as appropriate, add brief rationale accompanying each recommendation, and for the Governing Council to provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset.

MSS 630.044 Policy titled ***Sunset Mechanism for AMA-MSS Policy*** currently reads as following:

> AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-

MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council.

DISCUSSION

The MSS GC and Standing Committees conducted a review of policies adopted or reaffirmed by the MSS Assembly in 2017. Unfortunately, the Sunset Report was not submitted to the assembly at its original due date of Interim 2022 due to a combination of miscommunication during transition periods and changes in leadership structure. However, in this process, the Governing Council found that completing the Sunset review at the Annual Meeting provided the council with more time to receive Standing Committee input and review report recommendations. The time between Annual and Interim is typically very condensed with the Governing Council and Standing Committees getting settled into their roles, creating the Medical Student Section annual strategic plan, and preparing for the rapidly approaching November meeting. It was agreed upon by the GC that this process would likely be conducted with greater ease if the report deadline was scheduled for the AMA-MSS Annual meeting rather than at the AMA-MSS Interim meeting.

The Governing Council has made an additional amendment to our Sunset Report Mechanism which states that the MSS Governing Council may recommend policies for consolidation as part of the sunset review process. This concept is currently a part of our compendium of actions under 645.023MSS, however this policy is currently set for rescission by our A-23 Resolution Task Force.

As directed by the MSS Assembly at the Annual 2022 meeting, our Governing Council developed a formal mechanism for the Standing Committees to provide feedback on whether policies set to be removed from the policy compendium should be retained, retained with amendments, or sunset. The Governing Council met and created a flowsheet to guide standing committees to the final decision on policy recommendations. The Governing Council determined that in general, there should be a high threshold to sunset policies. Policies would be sunset only if the full action requested by the policy had been completed by the AMA (ex: Resolution asked for a study and the study was completed), or if the policy to be sunset is superseded by a more recently adopted resolution. It was determined that even if the MSS resolutions/actions have been adopted into HOD policy, the policy would be retained in the MSS Compendium of Actions as HOD policy may be amended or deleted at any time. Additionally, the Standing Committees were required to fill out a policy card, similar to those completed by caucus during the policy cycle, to assist them in answering the questions used for guidance on the decision-making flowsheet. With each final policy decision, a short paragraph with reasoning behind this decision was provided.

Appendix 1 of this report contains a listing of the 171 total policies adopted or reaffirmed in 2017, the recommendation for retention or GC Report A (A-23) rescission, and a brief supporting rationale for that recommendation, where needed. Some of these policies call for specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy.

The remaining policies contain policy that is still relevant, at least in part, and can be referenced by organizations or individuals seeking support for a particular issue. Of the 171 presented for consideration in this report, 169 of them will be either fully or partially retained as a part of the MSS policy compendium.

We have organized this report by recommendation, first by policies recommended for sunset, then by policies recommended for retention with amendments, and finally by policies recommended for retention as currently written.

In regard to the policies that were recommended to be retained with amendments, a majority of the amendments included changing terminology to fall in line with the recommendations by the AMA Center for Health Equity's Guide to Language, Narrative and Concepts, and incorporating friendly amendments proffered at the House of Delegates. There were many instances where policies listed had just been amendments to HOD policy, but listed the entirety of the HOD policy. In an attempt to consolidate our AMA-MSS Compendium of Actions, our Governing Council worked to incorporate the tenets of the requested amendments into AMA-MSS policy. There was one policy that we discussed where an effort for consolidation was made. We found that there were two policies (170.010MSS and 170.016MSS) regarding abstinence only education which were very similar, however, MSS policy 170.016 was a small amendment to a large AMA policy. The GC decided to incorporate the tenants of the amendments seen within 170.016MSS as a part of 170.010MSS in order to consolidate these policies.

The final recommendations of this report are as follows:

RECOMMENDATIONS

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.

2. The Governing Council's review of the Statements of Support will be addressed in the upcoming Resolution Task Force at A-23.

3. That AMA MSS policy 170.016MSS be rescinded.

4. That the AMA MSS policy 630.044MSS be amended by addition and deletion as follows:

> **630.044MSS Sunset Mechanism for AMA-MSS Policy**
> AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-

MSS Assembly at each ~~Interim~~ Annual Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; ~~and~~ (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council~~.~~; and (6) the MSS Governing Council may recommend policies for consolidation as part of the sunset review process.

APPENDIX 1 – Policy Sunset Report Recommendations for AMA-MSS Policies

RECOMMENDED FOR SUNSET

1. 165.007MSS - Steps in Advancing towards Affordable Universal Access to Health Insurance
2. 480.020MSS - Healthcare Applications for Blockchain Technology

RECOMMENDED FOR RETENTION WITH AMENDMENTS

3. 20.002MSS - AIDS Education
4. 65.012MSS - Removing Barriers to Care for Transgender Patients
5. 65.022MSS - Protection of Transgender Individuals' Right to Use Public Facilities in Accordance with Their Gender Identity
6. 65.023MSS - Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
7. 95.007MSS - Increased Advocacy for Needle Exchange Programs
8. 100.017MSS - Opioid Abuse in Breastfeeding Mothers
9. 100.018MSS - Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments
10. 120.014MSS - Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs
11. 130.005MSS - Air Ambulance Regulations and Reimbursements
12. 135.014MSS - Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability
13. 140.036MSS - Expansion of the Goldwater Rule
14. 150.026MSS - Programs to Combat Food Deserts
15. 150.039MSS - Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities
16. 160.036MSS - Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings
17. 165.020MSS - National Healthcare Finance Reform: Single Payer Solution
18. 165.022MSS - Expanding AMA's Position on Healthcare Reform Options
19. 170.010MSS - Abstinence-Only Education and Federally-Funded Community-Based Initiatives
20. 170.020MSS - Sex Education Materials for Students with Limited English Proficiency
21. 250.023MSS - Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief
22. 270.012MSS - Opposing Legislation of Medical Procedures
23. 295.011MSS - Regulation of Medical Student Education Opportunities
24. 295.144MSS - Support for Family and Relationships During Medical School and Residency
25. 295.166MSS - Expanding Clerkship Site Access to Include U.S. Medical Schools Undergoing Accreditation

26. 295.167MSS - Quality Improvement Education in Medical Schools and Residency Programs
27. 305.086MSS - Medical Student Dependent and Spousal Care
28. 310.054MSS - Preventing Resident Physician Suicide
29. 345.015MSS - Addressing Social Media Usage and its Negative Impacts on Mental Health
30. 350.001MSS - Minority and Disadvantaged Medical Student Recruitment and Retention Programs
31. 350.015MSS - Patient and Physician Rights Regarding Immigration Status
32. 440.041MSS - Accounting for Socioeconomic Status in Clinical and Public Health Research
33. 440.061MSS - Expanding Expedited Partner Therapy to Treat Trichomoniasis
34. 460.008MSS - Support for Increased Regulation in Tissue Procurement
35. 525.007MSS - Decreasing Sex and Gender Disparities in Health Outcomes
36. 525.008MSS - Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman
37. 525.009MSS - Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products
38. 655.028MSS - The Designation of Permanent Membership Positions Within Local AMA- MSS Chapters

RECOMMENDED FOR RETENTION

39. 5.007MSS - Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone
40. 15.004MSS - Hazards of All Terrain Vehicles
41. 20.020MSS - Increase Access to HIV PrEP for At-Risk Individuals
42. 50.002MSS - Use of Blood Therapeutically Drawn from Hemochromatosis Patients
43. 55.001MSS - Testicular Cancer Self Examination
44. 55.007MSS - Adolescent and Young Adult Cancer
45. 60.008MSS - School-Based Prevention of Eating Disturbances in Adolescents
46. 60.021MSS - Implementation and Funding of Childcare Services for Patients
47. 60.024MSS - Reporting Child Abuse in Military Families
48. 65.007MSS - Gender-Specific Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System
49. 95.006MSS - Comprehensive Evidence-Based Drug Treatment in Prisons
50. 95.008MSS - Cannabis and the Regulatory Void
51. 95.011MSS - Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis
52. 100.019MSS - Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians
53. 100.020MSS - Reforming the Orphan Drug Act
54. 100.021MSS - Opposing the Classification of Cannabidiol as a Schedule 1 Drug
55. 115.002MSS - Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being
56. 120.010MSS - Aligning Prescription Medication Renewals
57. 120.015MSS - Equalizing Reimbursement for Psychotherapy and Drug-Therapy

58. 135.015MSS - AMA Policy on Investing in the Fossil Fuel Industry
59. 135.016MSS - Mitigating Food Waste through Food Recovery
60. 140.013MSS - Out-of-Hospital Do-Not-Resuscitate (DNR) Orders
61. 140.026MSS - Assisted Suicide
62. 140.035MSS - Proposing Consent for De-Identified Patient Information
63. 140.037MSS - Non-Therapeutic Gene Therapies
64. 145.001MSS - Handgun Violence
65. 145.009MSS - Regulation of Handgun Safety and Quality
66. 150.032MSS - Defending Federal Child Nutrition Programs
67. 150.033MSS - Federal Agricultural Subsidy Reform
68. 150.034MSS - Identifying and Addressing Food Insecurity and Food Deserts Nationwide
69. 155.005MSS - Public Access to Chargemasters
70. 160.025MSS - Poverty Screening as a Clinical Tool for Improving Health Outcomes
71. 170.018MSS - Improving Safety and Health Code Compliance in School Facilities
72. 180.012MSS - Expanding Post-Mastectomy Options for Cancer Survivors
73. 180.014MSS - Antitrust Exemption for Health Insurance Companies
74. 200.015MSS - Supporting the Expansion of U.S. Residency Programs
75. 200.016MSS - Increasing Medical School Class Sizes
76. 245.011MSS - Protecting a Mother's Right to Breastfeed
77. 245.018MSS - Revision of Resuscitation Policies for Premature Infants Born at the Cusp of Viability
78. 245.019MSS - Support for Medicaid Reimbursement of Neonatal Male Circumcision
79. 245.021MSS - The Diaper Gap
80. 250.017MSS - Medical Tourism
81. 250.028MSS - Increasing Access to Healthcare Insurance for Refugees
82. 270.013MSS - Legislation of Medical Procedures
83. 270.019MSS - Implementation of Automated External Defibrillators in High School and College Sports Programs
84. 270.025MSS - Protecting the Patient and Physician Relationship from Legislative Regulation
85. 270.035MSS - Opposition to Capital Punishment
86. 270.036MSS - Evaluating Legislation on Substance Disorder Treatment Privacy and Confidentiality
87. 290.003MSS - Opposition to Medicaid Work Requirements
88. 290.004MSS - Medicaid Coverage of Fitness Facility Memberships
89. 295.005MSS - Availability of Medical Education
90. 295.086MSS - Curriculum Mandates for Licensure
91. 295.111MSS - State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam
92. 295.141MSS - Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students
93. 295.142MSS - Communication and Clinical Teaching Curricula
94. 295.168MSS - Expansion of Medical Spanish in US Medical Schools
95. 295.169MSS - Eliminating Legacy Admissions
96. 295.170MSS - Supporting Two-Interval Grading Systems for Medical Education
97. 295.171MSS - Health Policy Education in Medical Schools

98. 295.172MSS - Insurance Education for Medical Students
99. 295.173MSS - Policy and Advocacy Rotations for Medical Students
100. 295.192MSS - Medical Student Involvement and Validation of the Standardized Video Interview Implementation
101. 295.193MSS - Implicit Bias and Its Effects on healthcare and Its Incorporation into Undergraduate Medical Education
102. 295.194MSS - Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum
103. 305.043MSS - Tax Exemption for National Health Service Corps Scholarship
104. 305.060MSS - Solutions to Tackling the Increasing Cost of Medical Education
105. 305.061MSS - Student Loan Empowerment
106. 305.077MSS - Increasing Public Service Opportunities for Specialists
107. 305.083MSS - MSS Financial Burden of Application to Medical School and Residency
108. 305.084MSS - Medical School Tuition
109. 305.085MSS - Medical Students Federal Loans
110. 305.087MSS - Voluntary Service-Payback and Loan Repayment Programs
111. 305.088MSS - Increasing Availability and Access to Financial Aid
112. 305.089MSS - Medical Student Debt Management Education
113. 305.090MSS - Medical Student Loan Forgiveness
114. 310.019MSS - Notification of Interview Decision to Residency Program Applicants
115. 310.020MSS - Restrictive Covenants in Training Programs
116. 310.021MSS - Promoting Resident Involvement in Organized Medicine
117. 310.030MSS - Resident/Fellow Work and Learning Environment
118. 315.002MSS - Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals
119. 315.007MSS - Integration of Drug Price Information Into Electronic Medical Records
120. 345.014MSS - Co-Location of Behavioral Health Care and Primary Care
121. 345.016MSS - Reducing the Use of Restrictive Housing in Prisoners with Mental Illness
122. 350.013MSS - Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations
123. 350.016MSS - Improving Medical Care in Immigration Detention Centers
124. 350.017MSS - Disaggregation of Data Concerning the Status of Asian-Americans
125. 350.018MSS - Defense of Affirmative Action
126. 350.022MSS - Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities
127. 360.001MSS - Increasing the School Nurse to Student Ratio
128. 370.003MSS - Organ Donors and Transplants
129. 370.011MSS - Investigating the Possibility of a Unified Living Donor Kidney Registry
130. 370.012MSS - Organ Donation Education Programs in Driver Training Programs
131. 370.018MSS - Protecting Equity in Access to Kidney Dialysis and Transplant and Advocating for Patients' best Interest in End Stage Renal Disease
132. 405.006MSS - Non-Compete Clauses in Physician Contracts
133. 420.005MSS - Inclusion of Folic Acid Supplements in the Supplemental Nutrition Program
134. 420.010MSS - Infertility and Infertility Insurance Coverage

135. 435.008MSS - Error Disclosure and Physician Apologies
136. 440.017MSS Reducing the Risk of Flight-Associated Venous Thromboembolism
137. 440.018MSS - Childhood Obesity as a Public Health Epidemic
138. 440.039MSS - Support for Service Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership
139. 440.042MSS - Permitting Sunscreen in Schools
140. 440.062MSS - Addressing Foster Care Healthcare Needs
141. 440.063MSS - Recognizing Poverty-Level Wages as a Social Determinant of Health
142. 440.064MSS - Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data
143. 440.065MSS - Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
144. 440.066MSS - Opposition to Measures That Criminalize Homelessness
145. 440.067MSS - Food and Drug Administration Conflict of Interest
146. 440.068MSS - Support for Public Health Violence Prevention Programs
147. 440.075MSS - Support for Research of Boxes for Babies Sleeping Environment
148. 440.079MSS - Medical Respite Care for Homeless Adults
149. 440.080MSS - Ending Money Bail to Decrease Burden on Lower Income Communities
150. 460.020MSS - Reintroduction of Mitochondrial Donation in the United States
151. 460.021MSS - Researching Drug Facilitated Sexual Assault Testing
152. 480.010MSS - Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship
153. 480.011MSS - Use of Integrated Pre-hospital Electronic Patient Care Reports for Pre-hospital Healthcare Providers
154. 480.012MSS - Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology
155. 490.017MSS - Smoking Around Public Buildings
156. 500.004MSS - Picture-Based Warnings on Tobacco Products
157. 515.005MSS - Protection of the Privacy of Sexual Assault Victims
158. 515.008MSS - The Identification and Protection of Human Trafficking Victims
159. 515.010MSS - Sexual Assault Survivors' Rights
160. 515.011MSS - Increased Use of Body-Worn Cameras by Law Enforcement Officers
161. 515.012MSS - Collecting and Releasing Data on Law Enforcement Use of Force
162. 525.010MSS - Support for VA Health Services for Women Veterans
163. 530.012MSS - Product Endorsements
164. 630.074MSS - Review of AMA-MSS Statements of Support of HOD Policies
165. 640.014MSS - Regional Representation on MSS Committees
166. 645.012MSS - Health Policy Programming
167. 645.019MSS - European Medical Student Association (EMSA) – Official Observer
168. 645.034MSS - Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates
169. 655.018MSS - Membership Retention into Residency
170. 655.025MSS - Increasing the Efficiency of Student Membership Application Processing
171. 660.017MSS - Campaign Reform

RECOMMENDED FOR SUNSET

	Policy #	Title	Policy	Recommendation
1	165.007MSS	Steps in Advancing towards Affordable Universal Access to Health Insurance	(1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports *Expanding Health Insurance: The AMA Proposal for Reform*; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.	This policy is extremely redundant with existing policy. The AMA's plan for reform, referenced in clause (1), basically supports the components of the ACA, and the components of that plan are generally supported by 165.024MSS, which passed recently at A-21. Clause (2) supports ACP efforts in health systems reform; ACP now supports single payer, as does the MSS, so this is redundant, too. As noted by CEQM, clause (3) supports an AMA policy that no longer exists (and that also supports bipartisan health reform - which is not tenable given the rest of our policy and in the current political environment).
2	480.020MSS	Healthcare Applications for Blockchain Technology	AMA-MSS will study potential risks and benefits that blockchain technology may have on the healthcare industry, including but not limited to health care costs, security, interoperability, and claims adjudication.	The study has been completed, and the resultant recommendations may be found in 480.024MSS.

RECOMMENDED FOR RETENTION WITH AMENDMENTS

	Policy #	Title	Policy	Recommendation
3	20.002MSS	AIDS Education	AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils.	Recommend the following amendments to update our policy with more comprehensive language as follows: 20.002MSS HIV/AIDS Education: AMA-MSS: (1) encourages age- and grade-appropriate education of elementary, secondary, and college students, on the nature of HIV/AIDS, modes of HIV/AIDS transmission, recommended risk reduction strategies, and the national standards of care for their prevention and treatment starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a comprehensive understanding of the nature of HIV/AIDS, modes of HIV/AIDS transmission, recommended risk reduction strategies, the national standards-of-care for HIV/AIDS prevention and treatment, the

				availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils.
4	65.012MSS	Removing Barriers to Care for Transgender Patients	AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician.	Recommend replacing "treatment for gender dysphoria" with "gender affirming care", and including "gender diverse patient"s in the title, such that the policy reads as follows: <u>65.012MSS Removing Barriers to Care for Transgender and Gender Diverse Patients</u>: AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for gender affirming care in youth and adults; and (2) oppose categorical exclusions of coverage for gender affirming care in youth and adults when prescribed by a physician.
5	65.022MSS	Protection of Transgender Individuals' Right to Use Public Facilities in Accordance with Their	AMA-MSS supports transgender individuals' right to use public facilities in accordance with their gender identity to mitigate harms.	Recommend maintaining the relevance of the policy to current political movements by amending the title and body of the policy to read as follows:

		Gender Identity		65.022MSS Protection of Transgender Individuals' Right to Use Public Facilities in Accordance with Their Gender Identity and/or Gender Expression: AMA-MSS supports transgender and gender diverse individuals' right to use public facilities in accordance with their gender identity and/or gender expression to mitigate harms.
6	65.023MSS	Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals	AMA-MSS will ask that our AMA (1) publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+ population; (2) promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; (3) amend AMA policy H-65.976 by addition and deletion to read as follows: **Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H- 65.976** Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include	Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: AMA-MSS (1) supports the promotion of crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; and (2) recognizes 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

			"sexual orientation, sex, or gender identity" in any nondiscrimination statement. (4) amend AMA policy H-160.991 by addition and deletion to read as follows: **Health Care Needs of Lesbian Gay Bisexual and Transgender 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, ~~and~~ 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	partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

				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 LGBT 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 women who have sex with women to undergo regular cancer and sexually transmitted infection screenings 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~~; and~~ (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.	
7	95.007MSS	Increased Advocacy for Needle Exchange Programs	AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows: H-95.958 Syringe and Needle Exchange Programs The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.	Recommend incorporating the tenets of the amendments to AMA policy into AMA-MSS policy as follows: 95.007MSS Increased Advocacy for Needle Exchange Programs: AMA-MSS (1) supports physicians referring their patients to needle exchange programs; (2) supports legislation providing funding for needle exchange programs for persons who inject drugs; and (3) supports legislation that protects needle exchange program employees from prosecution for disseminating syringes.
8	150.039MSS	Food Advertising	AMA-MSS will ask the AMA to	Recommend updating the current

		Targeted to Black and Latino Youth Contributes to Health Disparities	(1) establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; (2) amend H-60.972 by addition and deletion to read as follows: Banning Food Commercials Aimed at Children H-60.972 (1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children; and (2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations.; and (3) work with appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations.	language and incorporate the tenants of the requested amendments of HOD policy as follows: 150.039MSS Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities: Our AMA-MSS supports (1) advocacy against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; (2) legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations; and (3) collaboration with appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations"
9	100.017MSS	Opioid Abuse in Breastfeeding Mothers	AMA-MSS (1) will ask that our AMA Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using	Recommend incorporating the tenets of the requested amendments into AMA-MSS policy as follows:

			opioid drugs or during maintenance therapy based on the most recent guidelines; and (2) will ask that our AMA amend by addition existing AMA policy H-420.962 Perinatal Addiction – Issues in Care and Prevention to read as follows: **Perinatal Addiction – Issues in Care and Prevention H-420.962** Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant <u>and breastfeeding</u> women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant <u>and breastfeeding</u> women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure,	<u>100.017MSS Opioid Abuse in Breastfeeding Mothers</u>: AMA-MSS (1) supports the promotion of educational resources for birthing parents who are opioid-dependent on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines; (2) supports making broadly available specialized treatment programs for pregnant and breastfeeding patients with substance use disorder; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for pregnant and breastfeeding patients with substance use disorder; (4) reaffirms that pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support

			and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant <u>and breastfeeding</u> patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy <u>and breastfeeding</u> and to routinely inquire about alcohol and drug use in the course of providing prenatal care.	rehabilitation; and (5) supports physicians increasing their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and routinely inquiring about alcohol and drug use in the course of providing prenatal care.
10	100.018MSS	<u>Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments</u>	AMA-MSS supports the efforts of the AMA Opioid Task Force and its goal to reduce opioid abuse.	This policy is relevant to support the recommendations of the Opioid Task Force (2017), but it has now become outdated given that the Opioid Task Force has been combined with the Pain Care Task Force into the Substance Use and Pain Care Task Force. Recommend amending to read as follows:

				100.018MS Research, Education and Awareness Regarding Non-Opioid Pain Management Treatment: AMA-MSS supports the efforts of the AMA Substance Use and Pain Care Task Force and its goal to reduce opioid abuse.
11	120.014MSS	Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs	AMA-MSS will ask that our AMA work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959.	Model legislation is already available from NABP report, the current AMA HOD language seems favorable and more specific to the original asks. Recommend amending to read as follows: 120.014MSS Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs: Our AMA-MSS supports encouraging: (1) states with laws establishing prescription drug repository and/or "return and reuse" programs to implement such laws and to consider integrating them with existing recycling or disposal programs; (2) states that lack drug repository and/or "return and reuse" programs to enact such laws in consultation with

				their state board of pharmacy; and (3) state medical associations in states where there is a prescription drug repository or a "return and reuse" program for unused medication supplies to educate physicians in their state regarding the existence of such programs.
12	130.005MSS	Air Ambulance Regulations and Reimbursements	AMA-MSS will ask that our AMA and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.	The original language asked that the AMA and relevant stakeholders study air ambulance services. CMS's resultant report on the subject also asked that stakeholders conduct those studies. Internal policy should be amended to eliminate the request for the report from the AMA, but the section about supporting study by external stakeholders should remain in case it is ever relevant. Recommend amending to read as follows: 130.005MSS Air Ambulance Regulations and Reimbursements: AMA-MSS supports relevant stakeholders studying the role, clinical efficacy, and

				cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvements.
13	135.014MSS	Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability	AMA-MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows: Support of Clean Air and Reduction in Power Plant Emissions H-135.949 Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants~~, substitution of natural gas in lieu of other carbon-based fossil fuels,~~ and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. (2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.	Retain with amendments to read as follows: 135.014MSS Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability: AMA-MSS (1) supports the continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels; (2) does not support substitution of natural gas in lieu of other carbon-based fossil fuels; and (3) supports the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.
14	140.036MSS	Expansion of the Goldwater Rule	AMA-MSS considers it unethical for a physician to offer a professional opinion about specific medical cases on individual patients unless he	As written, this policy asks the AMA to take a position on the matter of offering a professional opinion without conducting

			or she has conducted an examination and has been granted proper authorization for a public media statement.	an evaluation. The language of this resolution should be updated to be gender neutral to read as follows: <u>140.036MSS Expansion of the Goldwater Rule</u>: AMA-MSS considers it unethical for a physician to offer a professional opinion about specific medical cases on individual patients unless they have conducted an examination and have been granted proper authorization for a public media statement.
15	150.026MSS	<u>Programs to Combat Food Deserts</u>	AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows: D-150.978 Sustainable Food "Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through ~~the US Farm Bill~~ <u>tax incentive programs, community-level initiatives</u> and ~~other~~ federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public	Incorporate the friendly amendments proffered at the House of Delegates into AMA-MSS policy as follows: <u>150.026MSS Programs to Combat Food Deserts</u>: AMA-MSS supports the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation.

			about the importance of healthy and ecologically sustainable food systems.	
16	160.036MSS	Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings	AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, in the stead of patient family members and friends.	Policy 160.036MSS should be retained. While the AMA has indirectly been working on this resolved statement through encouraging the coverage of interpreter services by health plans, there is additional work that can be done, including campaigns to ensure available services are utilized. Recommend amendment to read as follows: 160.036MSS Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings: AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, instead of patient family members and friends.
17	165.020MSS	National Healthcare Finance Reform: Single Payer Solution	(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate	Recommend adding 165.024MSS to this policy as additional guidelines for intermediate health systems reforms on

			for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.	the path to single payer as follows: <u>165.020MSS Single Payer Solution</u>: AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS and 165.024MSS.
18	165.022MSS	<u>Expanding AMA's Position on Healthcare Reform Options</u>	AMA-MSS will ask the AMA to (1) rescind HOD policy H-165.844; (2) rescind HOD policy H-165.985; (3) amend by deletion HOD policy H-165.888 as follows: Evaluating Health System Reform Proposals H-165.888 1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: a. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs. b. ~~Unfair concentration of market power of~~	Recommend amending to incorporate the tenets of the requested amendments to HOD policy as follows: <u>165.022MSS Expanding AMA's Position on Healthcare Reform Options:</u> AMA-MSS supports removing opposition to single payer from AMA policy.

			~~payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.~~ c. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and	

			present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. e. And national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce and adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. g. All civilian federal government	

			employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. h. True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislations. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorder and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients; and	

			(4) amend by deletion HOD policy 165.838 as follows: Health System Reform Legislation H-165.838 1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: (a) Health insurance coverage for all Americans; (b) Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; (c) Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; (d) Investments and incentives for quality improvement and prevention and wellness initiatives; (e) Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; (f) Implementation of	

			medical liability reforms to reduce the cost of defensive medicine; (g) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens. 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange by self-supporting, have uniform solvency	

			requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that	

			widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system; (c) Medicare payment cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted; (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; (f) arbitrary 9. restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest. Our AMA will continue to	

			actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. ~~AMA policy is that creation of a new single payer, government run health care system is not in the best interest of the country and must not be a part of national health system reform.~~ 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive	

			medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.	
19	170.010MSS	Abstinence-Only Education and Federally-Funded Community-Based Initiatives	AMA-MSS supports initiatives to: (1) extend AMA support of comprehensive family- life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence.	Policy 170.010MSS and 170.016MSS are very similar. Recommend an amendment to incorporate both policies into one location while maintaining the spirit of 170.016MSS, so that we are able to rescind 170.016MSS and clean up our compendium of actions. Recommend amendments as follows: 170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives: AMA-MSS supports initiatives to: (1) extend AMA support of comprehensive, developmentally appropriate sexuality education programs at all education levels that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a

				reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall

				health education program; (2) Continue monitoring research findings related to emerging initiatives that include abstinence-only, school based sexuality education, consent communication to prevent dating violence and reduce substance use while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people, and report back to the House of Delegates as appropriate; (3) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program (4) Oppose the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (5) Endorse the use of comprehensive family life education

				in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; and (6) Continue the development of sexual education curricula that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse. Followed by the rescission of 170.016MSS.
20	170.020MSS	<u>Sex Education Materials for Students with Limited English Proficiency</u>	Our AMA- MSS will ask our AMA to amend policy H-170.968 by insertion as follows: Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968 (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive,	<u>170.020MSS Sex Education Materials for Students with Limited English Proficiency</u>: AMA-MSS urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils.

				developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternative in birth control, and other issues aimed prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the	

			program; and (g) are part of an overall health education program; (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family	

			life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and sager sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community- based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health and conversations about consent;	

			(10) Encourages physicians and all interested parties to develop best-practice, evidence-based guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.	
21	250.023MSS	Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief	AMA-MSS (1) supports the efforts of the Global Health Service Partnership to strengthen African healthcare workforces; and (2) recognizes the benefits of including loan repayment in the Global Health Service Partnership funded from a variety of sources.	Policy 250.023MSS should be retained with amendments. While these resolved clauses are still relevant, the language should be amended to include all US government programs, including PEPFAR and Global Health Service Partnership, which strengthen the healthcare workforces in all low-and-middle income countries, not only in Africa. No definitive action has been taken on the part of AMA regarding this policy and therefore policy 250.023MSS remains relevant to our section. Recommend amendments as follows: 250.023MSS Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief: Our AMA-MSS (1) supports the efforts of the US

				Government programs to strengthen global healthcare workforces; and (2) recognizes the benefits of including loan repayment in the US Government programs funded from a variety of sources.
22	270.012MSS	Opposing Legislation of Medical Procedures	AMA-MSS strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient.	This policy is important to retain as it provides an important framework for advocacy on more specific topics such as reproductive health and can support advocacy on many different types of legislation. However, this language should be amended for gender inclusivity as follows: 270.012MSS Opposing Legislation of Medical Procedures: AMA-MSS strongly condemns any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
23	295.011MSS	Regulation of Medical Student Education Opportunities	AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other	This is a very broad policy that is still being worked on by our AMA. Adding the DO accrediting body within this policy would be more

			efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians.	inclusive. Recommend amendments as follows: 295.011MSS Regulation of Medical Student Education Opportunities: AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME and COCA standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians.
24	295.144MSS	Support for Family and Relationships During Medical School and Residency	(1) AMA-MSS will work with the RFS, the AMA Alliance, and other interested organizations to (a) urge medical schools and residency programs to provide access to and encourage use of relationship counseling; (b) encourage medical schools and residency programs to offer workshops, activities, or lectures regarding the balance of family life with medical training and practice; and (c) promote opportunities for student and resident spouses and partners to become involved in the medical community, particularly through the AMA Alliance.	In an effort to make this policy more actionable at the level of the AMA-MSS, the following amendments are proffered. Suggest amendments to incorporate consideration of an MSSAI if members would like to pursue a specific intersectional effort on this topic as follows: 295.144MSS Support for Family and Relationships During Medical School and Residency: 1) Our

				AMA-MSS will support: (a) medical schools and residency programs to provide access to and encourage use of relationship counseling; (b) medical schools and residency programs to offer workshops, activities, or lectures regarding the balance of family life with medical training and practice; and (c) promotion of opportunities for student and resident spouses and partners to become involved in the medical community, particularly through the AMA Alliance."
25	295.166MSS	Expanding Clerkship Site Access to Include U.S. Medical Schools Undergoing Accreditation	AMA-MSS will ask the AMA to amend Policy D-295.320 by insertion as follows: D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education Our American Medical Association will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools	Move to incorporate the tenets of the requested amendments into AMA-MSS policy as follows: 295.166MSS Expanding Clerkship Site Access to Include U.S. Medical Schools Undergoing Accreditation: AMA-MSS advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-

			and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.	approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.
26	295.167MSS	Quality Improvement Education in Medical Schools and Residency Programs	AMA-MSS will (1) advocate to medical school deans for the inclusion of quality improvement education in medical school curricula; (2) encourage the American College of Medical Quality, the Association of American Medical Colleges, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, the Commission on Osteopathic Colleges Accreditation, and other relevant bodies to develop a basic set of core competencies in medical quality improvement that all medical school curricula should include; (3) encourage the American College of Medical Quality and other appropriate organizations to develop a guideline curriculum in medical	Recommending amendments to make this policy more relevant to the MSS and improve its actionability, as follows: 295.167MSS Quality Improvement Education in Medical Schools and Residency Programs: Our AMA-MSS supports (1) inclusion of quality improvement education in medical school curricula; (2) development of a basic set of core competencies in medical quality improvement that all

			quality improvement to be made available to medical schools; and (4) work with relevant parties to monitor the national implementation of quality improvement education in medical school curricula and report back to the Medical Student Section.	medical school curricula should include by the American College of Medical Quality, the Association of American Medical Colleges, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, the Commission on Osteopathic Colleges Accreditation, and other relevant bodies; (3) development a guideline curriculum in medical quality improvement to be made available to medical schools by the American College of Medical Quality and other appropriate organizations; and (4) monitoring the national implementation of quality improvement education in medical school curricula and report back to the Medical Student Section.
27	305.086MSS	<u>Medical Student Dependent and Spousal Care</u>	The AMA-MSS supports the following principles regarding the care of medical school students' spouses and dependents: 1. That the AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include	Recommend rescinding item 3 of this policy. At this time, this specific ask is not actionable as currently written. Recommended final language is as follows:

			costs for food, shelter, clothing, healthcare, and dependent care for all dependents. 2. That the AMA-MSS supports and will ask the AMA to work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent, spousal and same-sex spousal equivalent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense in medical student financial aid budgets. 3. That the AMA-MSS ask its Council on Medical Education, Academic Physician Section and Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses. 4. The AMA-MSS supports and will ask the AMA to support the Parent Loan Program and its expansion so that parents and spouses of medical students can borrow at less than market rates.	305.086MSS Medical Student Dependent and Spousal Care: The AMA-MSS supports the following principles regarding the care of medical school students' spouses and dependents: 1. That the AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, healthcare, and dependent care for all dependents. 2. That the AMA-MSS supports and will ask the AMA to work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent, spousal and same-sex spousal equivalent health insurance, dependent

				care, and dependent living expenses be included both as part of the “cost of attendance” and as an educational expense in medical student financial aid budgets. 3. The AMA-MSS supports and will ask the AMA to support the Parent Loan Program and its expansion so that parents and spouses of medical students can borrow at less than market rates.
28	310.054MSS	<u>Preventing Resident Physician Suicide</u>	AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities.	Move to retain with an amendment to change the title of this policy to "Resident Physician Mental Health" in order to be more encompassing, as follows: <u>310.054MSS Preventing Resident Physician Suicide</u>: AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2)

				encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities.
29	345.015MSS	Addressing Social Media Usage and its Negative Impacts on Mental Health	AMA-MSS will ask that our AMA (1) collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians' knowledge of the health impacts of social media usage, and (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and (2) advocate 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 usage.	The current MSS policy is similar to the HOD policy that was created as a result of this policy. However, the HOD policy added three more clauses, all of which are within the spirit of this policy and expand upon it. Therefore, it is recommended that this policy be retained with amendments to include the three clauses in HOD policy as follows: 345.015MSS Addressing Social Media Usage and its Negative Impacts on Mental Health: The AMA-MSS will ask that our AMA (1) collaborate with relevant professional organizations to (a) develop continuing

				education programs to enhance physicians' knowledge of the health impacts of social media usage, (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; (2) advocate 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 usage; (3) affirm 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) advocate for and support media and social networking services addressing and developing safeguards for users; and (5) advocate for the study of the positive and negative biological,

				psychological, and social effects of social media and social networking services use.
30	350.001MSS	Minority and Disadvantaged Medical Student Recruitment and Retention Programs	AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose economically disadvantaged students to the career of medicine; special summer programs to bring minority and economically disadvantaged students to medical schools for an intensive exposure to medicine; and conduct retention programs for minority and economically disadvantaged medical students who may need assistance.	Recommend retaining 350.000MSS with amendments to update this policy to fall in line with the Center for Health Equity's Guide to Language, Narrative and Concepts as follows: 350.001MSS Marginalized and Minoritized Medical Student Recruitment and Retention Programs: AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose students from first generation and lower socioeconomic backgrounds to the career of medicine; special summer programs to bring students facing financial barriers to medical schools for an intensive exposure to medicine; and conduct retention programs for marginalized and minoritized medical students who may need assistance.
31	350.015MSS	Patient and Physician	AMA-MSS will ask the AMA to support protections that prohibit	This MSS policy is asking the AMA to

		Rights Regarding Immigration Status	U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.	take a position (e.g. to support protections that prohibit the use of medical records for immigrations enforcement of undocumented immigrants). The AMA has successfully adopted this position in its own policy and has taken actions in line with the spirit of this policy. However, the policy continues to provide an important point of leverage for MSS advocacy on behalf of healthcare protections for undocumented immigrants, so recommend that the policy be amended to read as follows: 350.015MSS Patient and Physician Rights Regarding Immigration Status: Our AMA-MSS supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
32	440.041MSS	Accounting for	AMA-MSS will ask the AMA to study the literature regarding	This resolution asks the AMA to study this

		Socioeconomic Status in Clinical and Public Health Research	the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards.	issue. It looks like the AMA adopted alternate language encouraging study of the issue, but never studied it itself. Recommend retaining with an amendment to change to current AMA language in H-460.980 as follows: 440.041MSS Accounting for Socioeconomic Status in Clinical and Public Health Research: AMA-MSS encourages the study of the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards.
33	440.061MSS	Expanding Expedited Partner Therapy to Treat Trichomoniasis	AMA-MSS will ask that our AMA amend policy H-440.868 by addition and deletion as follows: **Expedited Partner Therapy H-440.868** Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, ~~and/or~~ chlamydia, and/or trichomoniasis infection.	Recommend that this policy be retained with amendments of those that were ultimately adopted by the HOD which were successfully passed in spirit. This would help to more clearly establish internal policy. Amend as follows: 440.061MSS Expanding Expedited Partner Therapy to Treat Trichomoniasis: AMA-MSS supports legislation that permits physicians to provide expedited

				partner therapy to patients diagnosed with sexual transmitted infections, including gonorrhea, chlamydia, and trichomoniasis.
34	460.008MSS	Support for Increased Regulation in Tissue Procurement	AMA-MSS will ask the AMA to (1) support efforts by the FDA, the American Association of Tissue Banks, CDC, and other appropriate establishments to institute a uniform system of tissue tracking and a national database of tissue registry for tissues intended for nonclinical scientific and educational purposes; and (2) reaffirm AMA Policy H-370.988 – Regulation of Tissue Banking.	Recommend amending this policy as follows: 460.008MSS Support for Increased Regulation in Tissue Procurement: AMA-MSS supports efforts by the FDA, the American Association of Tissue Banks, CDC, and other appropriate stakeholders to institute a uniform system of tissue tracking and a national database of tissue registry for tissues intended for nonclinical scientific and educational purposes.
35	525.007MSS	Decreasing Sex and Gender Disparities in Health Outcomes	AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.	This policy continues to be extremely relevant and warrants maintaining it as a position of the AMA-MSS. Given the recent legislation across the country banning evidence-based medicine practices specific to transgender, gender non-conforming, and pregnant patients this policy has renewed importance. Further, continuing to emphasize the

				evidence-based medicine which is used in the production of guidelines, protocols, and decision support tools for treatment, this policy should remain in place. The previous language of this policy was focused primarily on biological differences “between sexes,” however to be gender inclusive based on the title of the policy, “Decreasing Sex and Gender Disparities in Health Outcomes” the changes below are necessary and apply universally. Particularly for transgender or non-binary patients, it is the patient’s current anatomy which must be considered in regard to treatment guidelines, protocols, and support tools, rather than the sex they were assigned at birth. Moreover, this change is more accurate to patient care for all patients, for example if a patient no longer has a uterus and cervix, protocol regarding cervical cancer screening may change. This change is also consistent with existing policy such as 65.026 which

				supports the use of organ inventory in the electronic medical record to improve care. Recommend amending the policy to read as follows: 525.007MSS Decreasing Sex and Gender Disparities in Health Outcomes: AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to individual patient anatomy for conditions in which physiologic and pathophysiologic differences exist based on anatomical differences.
36	525.008MSS	Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman	AMA-MSS will ask the AMA to (1) classify, and encourage the Internal Revenue Service to classify, feminine hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of feminine hygiene products; and (3) support consistent and ready access of feminine hygiene products across all publicly funded institutions,	This policy remains relevant and has not been replaced/contradicted by newer policy. Recommend to amend the policy to adopt gender neutral language to read as follows: 525.008MSS Improved

			including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged women.	Accessibility of Menstrual Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman AMA-MSS will ask the AMA to (1) classify, and encourage the Internal Revenue Service to classify, menstrual hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of menstrual hygiene products; and (3) support consistent and ready access of menstrual hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged individuals.
37	525.009MSS	Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products	AMA-MSS 1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products.	This policy is still relevant, and there have been no new policies passed to contradict it. Suggest amending language from feminine hygiene products to menstrual hygiene products, such that the policy reads as follows:

				525.009MSS Improving Transparency in Ingredient Lists for Cosmetic and Menstrual Hygiene Products: AMA-MSS 1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and menstrual hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including menstrual hygiene products.
38	655.028MSS	The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters	AMA-MSS strongly encourages every medical school to designate a permanent position within their chapter to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the chapter provide the individual's name and current mailing address to the AMA Medical Student Section Outreach Program prior to each Annual Meeting.	Recommend minor language changes to change the term "chapter" to "local chapter leader" and to allow provision of local chapter leader information to AMA Medical Student Section Staff and Region Leaders as follows: 655.028MSS The Designation of Permanent Membership Positions Within Local AMA- MSS Chapters: AMA-MSS strongly encourages every medical school to designate a permanent position within their local

				campus local campus section to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the local campus section provide the individual's name and current mailing address to the AMA Medical Student Section Staff and Region leadership prior to each Annual Meeting.

RECOMMENDED FOR RETENTION

	Policy #	Title	Policy	Recommendation
39	5.007MSS	Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone	AMA- MSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone.	AMA policy H-100.948 "Supporting Access to Mifepristone" covers the asks of this MSS policy, including lifting of the Risk Evaluation and Mitigation Strategy on Mifepristone. In addition, as part of the AMA policy supporting mifepristone for reproductive health, ACOG and AMA have sent several correspondences, both to the White House and Congress on this issue. However, given the ongoing uncertainty of reproductive care in the aftermath of the Dobbs decision, this policy remains relevant and actionable.
40	15.004MSS	Hazards of All Terrain Vehicles	AMA-MSS will ask the AMA to support increased safety standards for the operation of all-terrain vehicles.	No contradictory policy has been passed by the AMA or AMA-MSS with respect to this resolution. However,

				there are several policies that align with the spirit of this resolution. Unfortunately, there seems to have been no action by the AMA establishing this support externally.
41	20.020MSS	Increase Access to HIV PrEP for At-Risk Individuals	AMA-MSS supports PrEP referral at needle exchange sites.	The need for this advocacy is still very relevant. Retaining this policy will continue to provide beneficial information/referrals to these at risk populations.
42	50.002MSS	Use of Blood Therapeutically Drawn from Hemochromatosis Patients	AMA-MSS will ask the AMA to advocate the acceptance of blood drawn therapeutically from patients with hemochromatosis as a measure to correct the shortage in the blood supply, provided that methods are in place to ensure the donor's altruistic intent to use the blood for transfusion.	AMA policy H-50.979 incorporates a portion of the asks within this policy, but does not address the potential use of therapeutic phlebotomy to address blood shortages as asked by this MSS policy. As a result, policy is suitable to retain.
43	55.001MSS	Testicular Cancer Self Examination	AMA-MSS will ask the AMA to promote national awareness of the problem of testicular cancer and to support programs of education in the proper method of self-examination to lead to early detection of testicular cancer.	This policy asks the AMA to take a position in support of education and awareness surrounding testicular cancer and self-examination. No contradictory policy has been passed by the AMA or AMA-MSS with respect to this resolution. Unfortunately, there seems to have been no recent action by the AMA on this.
44	55.007MSS	Adolescent and Young	(1) AMA-MSS encourages further research into the scientific	This policy seeks to encourage research

		Adult Cancer	basis, treatment, and diagnosis of Adolescent and Young Adult Cancers; and (2) AMA-MSS promotes education and research about the unique challenges to treating adolescents and young adults with cancer and promote solutions to these challenges.	and further research into adolescence and young adult cancer as well as promote education and research into unique challenges of this age group. There is no relevant AMA actions or HOD policy addressing the concerns stated in this policy. Therefore, it should be retained.
45	60.008MSS	School-Based Prevention of Eating Disturbances in Adolescents	AMA-MSS will ask the AMA to encourage all school counselors, coaches, trainers, teachers and nurses to be trained to recognize unhealthy dieting and weight restrictive behaviors in adolescents and offer education and appropriate referral for interventional counseling.	There is no policy by the MSS that directly contradicts this and there has been no movement or action by the AMA since the policy that supports it.
46	60.021MSS	Implementation and Funding of Childcare Services for Patients	AMA-MSS will ask the AMA to encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients.	This policy remains relevant. No position has not yet been taken on the issue by the AMA as it relates to childcare specifically for patients.
47	60.024MSS	Reporting Child Abuse in Military Families	AMA-MSS will ask the AMA to support all state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.	Policy 60.024MSS should be retained. The only mention of the policy similar to it, H-515.960, was for the announcement of its adoption, and no advocacy or actions have been taken. As such, policy 60.024MSS will remain relevant to our section.
48	65.007MSS	Gender-Specific Rehabilitative Programs, Mental	AMA-MSS will ask the AMA to work with appropriate organizations to evaluate gender-specific rehabilitation programs, mental health services, and educational	Although there is existing policy related to improvements in health care and treatment of individuals in

		Health, and Educational Services for Girls in the Juvenile Detention System	services in juvenile detention centers.	detention centers there are currently no AMA policies specifically advocating for gender-specific programs for juveniles in detention centers. The asks of this policy remain novel and relevant.
49	95.006MSS	Comprehensive Evidence-Based Drug Treatment in Prisons	AMA-MSS will ask the AMA to work with appropriate specialty societies to develop and promote legislative and policy initiatives that expand comprehensive evidence-based substance abuse treatment in federal, state and local prisons and jails.	The AMA has produced multiple policy statements and continues to work in this field and advocates for substance abuse treatment for justice-related individuals. This policy remains relevant to our section.
50	95.008MSS	Cannabis and the Regulatory Void	AMA-MSS believes that although cannabis is a mind-altering drug whose use may have unforeseen consequences; (1) federal and state governments should abolish all criminal penalties relating to consumption or possession of cannabis; (2) the sale of cannabis for medicinal use should be regulated according to evidence-based research; and (3) additional research should be encouraged.	The AMA remains actively involved in legislation involving this topic. Considering that many states have not abolished criminality revolving cannabis or its paraphernalia, it is important that this policy be retained.
51	95.011MSS	Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis	AMA- MSS will ask that our AMA work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services.	95.011MSS is a timely policy that seeks to reduce the spread of blood borne illness and improves public and community health workers outreach to individuals with SUDs. This topic has not been addressed in another MSS policy. H-95-925 has a similar scope, but less active and

				specific instructions for the AMA.
52	100.019MSS	Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians	AMA-MSS will ask the AMA to support non-fatal and fatal opioid overdose reporting to the appropriate agencies.	This policy should remain in our compendium of actions as the work related to this has not been fully completed.
53	100.020MSS	Reforming the Orphan Drug Act	AMA-MSS will ask the AMA to (1) support legislation and policy efforts to reform the Orphan Drug Act by closing loopholes identified by the FDA in order to protect the Act's original intent of promoting therapies targeting rare diseases; (2) support increased transparency in development costs, post-approval regulation, overall earnings, and off-label uses for pharmaceuticals designated as "Orphan Drugs"; and (3) support efforts to modify the exclusivity period of "Orphan Drugs" in order to increase access to these pharmaceutical drugs.	The MSS has made any recent policy changes in opposition to this specific policy. The requests of this policy have not been completely accomplished by the AMA, therefore recommend that it be retained.
54	100.021MSS	Opposing the Classification of Cannabidiol as a Schedule 1 Drug	AMA-MSS will ask the AMA to support the reclassification of Cannabidiol (CBD) as a non-scheduled drug.	The AMA has supported the changing of the marijuana scheduling for the purpose of research in 2019, but there has been no further action. Seeing as the resolved clause seeks a change in the overall scheduling of marijuana—not only in the setting of research—the clause should be retained.
55	115.002MSS	Advocacy for a System of	AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other	While the AMA has policy supporting increased health

		Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being	appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed.	literacy efforts for medication instructions, the full asks of this policy have not been realized.
56	120.010MSS	Aligning Prescription Medication Renewals	AMA-MSS will ask the AMA to encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the travel barriers for prescription acquisition.	Educational efforts have been completed for AMA members, however, there has not been evidence of meaningful collaboration with insurance companies or pharmacy organizations to develop these schedules in practice.
57	120.015MSS	Equalizing Reimbursement for Psychotherapy and Drug-Therapy	AMA-MSS supports comparable reimbursement rates per unit of time spent with patients for physician provided psychotherapy and pharmacotherapy where comparable efficacy has been demonstrated.	This policy remains relevant to the MSS and should be retained.
58	135.015MSS	AMA Policy on Investing in the Fossil Fuel Industry	AMA-MSS supports (1) the American Medical Association, Foundation, and any affiliated corporations, to work in a timely and fiscally responsible manner to end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of	There is a continued need for MSS to support the efforts of physicians and other health professional associations to proceed with divestment from fossil fuel companies.

			fossil fuels; (2) the AMA, when fiscally responsible, to choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers.	
59	135.016MSS	Mitigating Food Waste through Food Recovery	AMA-MSS will ask the AMA to (1) prioritize sustainability and mitigation of food waste in vendor and venue selection and (2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation.	The AMA has passed this policy and has acted by writing a letter to the FDA with recommendations to minimize food waste. The topic is still relevant, and more work can be done.
60	140.013MSS	Out-of-Hospital Do-Not-Resuscitate (DNR) Orders	AMA-MSS supports the rights of terminally and chronically ill patients to have their DNR orders honored by emergency personnel in all out-of-hospital settings in so far that adequate proof and documentation of the patients' DNR status can be provided in an emergency situation (i.e., medic alert bracelet, etc.).	This policy addresses the important issue of respecting a patient's DNR status outside of the hospital with appropriate proof and documentation.
61	140.026MSS	Assisted Suicide	AMA-MSS recognizes that situations may exist where it would be ethically acceptable for patients to choose to end their own lives.	This resolution has not been contradicted by more recent MSS policy and asks our MSS to support a position contrary to that of Code of Medical Ethics guidance.
62	140.035MSS	Proposing Consent for De-	AMA-MSS will ask the AMA to study the handling of de-identified patient information by	While this study generated several reports and at least

		Identified Patient Information	covered entities for third party commercial use and report findings and recommendations back to the AMA House of Delegates	one new AMA policy on the issue, it appears that CEJA's review of the issue is on-going, as CEJA Report 4-I-22 indicates. Recommend retaining this policy until CEJA's review is complete.
63	140.037MSS	Non-Therapeutic Gene Therapies	AMA-MSS will ask the AMA to partner with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies.	This policy remains relevant and should be retained.
64	145.001MSS	Handgun Violence	The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns.	With the recent announcement of the Gun Violence Task Force, retaining this policy will continue our steadfast commitment to tackling the firearm violence public health crisis and ensure the MSS can continue to advocate on this topic. Recommend retention.
65	145.009MSS	Regulation of Handgun Safety and Quality	AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns.	With the recent announcement of the Gun Violence Task Force, retaining this policy will continue our steadfast commitment to tackling the firearm violence public health

				crisis and ensure the MSS can continue to advocate on this topic. Recommend retention.
66	150.032MSS	Defending Federal Child Nutrition Programs	AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirm H-150.962 Quality of School Lunch Program.	Internal policy that remains relevant. Recommend retention.
67	150.033MSS	Federal Agricultural Subsidy Reform	AMA-MSS supports (1) efforts to limit the consumption of foods and beverages that contain added sweeteners by changes to the federal agricultural subsidies system; and (2) the adjustment of federal subsidies toward the preferential subsidization of crops and food products that are consistent with evidence based guidelines for good nutrition and healthy eating patterns.	This policy remains relevant and should be retained.
68	150.034MSS	Identifying and Addressing Food Insecurity and Food Deserts Nationwide	AMA- MSS supports (1) research on the impact of factors influencing functional access to food including but not limited to gentrification, transportation, and crime rates on the development of food deserts; (2) the creation of new tools aimed at identifying food deserts taking into account cost of food in geographically accessible stores or modification of existing tools for identification of food deserts to include consideration of affordability in the establishment of accessibility of healthy food sources; and (3) current efforts by the United States Department of Agriculture in the incorporation of nutrition education programs focusing on sustainable food sourcing and the impact of healthy foods on overall well-being including but not limited to those involving school and community garden building and education on healthy eating habits.	In light of the pandemic and rising costs, food insecurity is even more pertinent, and more actions can be taken to address the national issue of food insecurity and food deserts.

69	155.005MSS	Public Access to Chargemasters	AMA-MSS supports legislation requiring health- care institutions to provide public online access to their complete and current chargemaster in a searchable, consumer-friendly format that includes reference codes, descriptions, and prices.	This policy asks the AMA to support transparent pricing and public chargemasters. DHHS did make this a requirement in 2019, as supported by this policy. However, this policy remains relevant to our Section.
70	160.025MSS	Poverty Screening as a Clinical Tool for Improving Health Outcomes	AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources.	While the AMA has adopted supporting policy and has begun to increase physician education about social determinants of health (SDH), actions to support the development of standardized, validated questionnaires to screen for SDH and improve care plans has not been carried out to the fullest extent.
71	170.018MSS	Improving Safety and Health Code Compliance in School Facilities	AMA-MSS will ask our AMA to (1) support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections; (2) support policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods; and (3) support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure.	This policy remains relevant to our Section and should be retained.
72	180.012MSS	Expanding Post-Mastectomy Options for	AMA-MSS will ask the AMA to recommend that third party payors provide coverage and reimbursement for medically	While HOD policy H-55.973 makes this exact recommendation,

		Cancer Survivors	beneficial breast cancer treatments including but not limited to prophylactic contralateral mastectomy.	and most third-party payers do provide such coverage. There is no MSS policy in opposition. Recommend retention.
73	180.014MSS	Antitrust Exemption for Health Insurance Companies	AMA-MSS will ask the AMA to urge federal authorities to oppose antitrust exemption status for health insurance companies.	Given that the MSS has not passed any other policy in opposition and the ask of this policy has not been fully accomplished, recommend this policy be retained.
74	200.015MSS	Supporting the Expansion of U.S. Residency Programs	AMA-MSS supports increases in the number of residency positions according to AMA workforce studies, where such increases would not undermine existing physician residency positions in any of the states.	This continues to be an issue that is reaffirmed by the HOD and the MSS as a vital issue worth advocating. Since adoption by the MSS in 2007, the AMA has advocated for pilot programs for expansion of positions, and expansion of funding. It looks like there is still space for more work. Recommend retention.
75	200.016MSS	Increasing Medical School Class Sizes	AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education.	Internal policy that remains relevant. Recommend retention.
76	245.011MSS	Protecting a Mother's Right to Breastfeed	AMA-MSS supports state legislation that clarifies and enforces a mother's right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother's right to breastfeed in a public place.	Although our AMA has taken steps to support protections related to breastfeeding in certain public locations such as schools, retaining this policy will ensure that there be continued advocacy related to

				ensuring a mother's right to breastfeed in any public space.
77	245.018MSS	Revision of Resuscitation Policies for Premature Infants Born at the Cusp of Viability	AMA-MSS supports programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability.	Internal policy that remains relevant. Recommend retaining this policy.
78	245.019MSS	Support for Medicaid Reimbursement of Neonatal Male Circumcision	AMA-MSS will ask the AMA to (1) encourage state Medicaid reimbursement of neonatal male circumcision; and (2) update current policy to support the general principles of the revised 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads "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."	After many states defunded Medicaid coverage of circumcision following the American Academy of Pediatrics equivocal statement in 1999, the AAP came out with a statement of support for the potential benefits of circumcision. While the AMA has adopted this as official policy, little has been done to encourage state Medicaid coverage and there are no other policies in contradiction.
79	245.021MSS	The Diaper Gap	AMA-MSS will ask that our AMA support increased access to affordable diapers.	Does not conflict with AMA or AMA-MSS policy and more action needs to be done to complete this task. Therefore, this policy should be retained.
80	250.017MSS	Medical Tourism	AMA-MSS supports informing patients about potential risks and benefits of going abroad to receive medical treatment.	Does not conflict with AMA or AMA-MSS policy and remains relevant. Recommend retention.

81	250.028MSS	Increasing Access to Healthcare Insurance for Refugees	AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees, and (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans.	While the AMA has done considerable advocacy for refugees, little action has been focused specifically on the second resolved related to insurance plan enrollment.. The MSS has not passed any more recent policy in opposition. Recommend retention.
82	270.013MSS	Legislation of Medical Procedures	AMA-MSS will ask the AMA to work to ensure that if legislation seeks to regulate a medical procedure, the bill language utilizes standard medical terminology recognized by physicians to describe the procedure precisely.	Internal policy that remains relevant. Recommend retention.
83	270.019MSS	Implementation of Automated External Defibrillators in High School and College Sports Programs	AMA-MSS will ask the AMA to (1) support state legislation and/or state educational policies encouraging each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator (AED) and trained personnel on its premises; and (2) support state legislation and/or state educational policies encouraging athletic coaches, sports medicine personnel, and student athletes to be trained and certified in CPR, AED, basic life support, and recognizing the signs of sudden cardiac arrest.	This policy remains relevant. Recommend retention.
84	270.025MSS	Protecting the Patient and Physician Relationship from Legislative Regulation	AMA-MSS (1) opposes legislation that requires physicians to perform medical procedures without valid medical indication or contrary to standards of care, especially as it concerns mandates to perform fetal ultrasounds on patients; and (2) opposes legislation that mandates specific counseling by physicians to patients, including	This topic is still relevant. Recommend retention.

			mandatory viewing and description of fetal ultrasound images or required listening of fetal heart sounds.	
85	270.035MSS	Opposition to Capital Punishment	AMA-MSS opposes all forms of capital punishment.	This policy is not contradicted by recent MSS policy. Recommend retention.
86	270.036MSS	Evaluating Legislation on Substance Disorder Treatment Privacy and Confidentiality	AMA-MSS supports the study of the implications of 42 CFR Part 2 under current law, as well as the proposed alignment of substance use disorder confidentiality requirements with HIPAA, with respect to: 1) Harm due to unwanted disclosure of Substance Use Disorder (SUD) diagnosis and treatment information, including legal, social, emotional, and psychological outcomes; 2) Harm due to non-disclosure of Substance Use Disorder (SUD) diagnosis and treatment information to other health care providers; and 3) Deterrence of patients from seeking treatment for SUDs.	This issue remains highly relevant, and this policy highlights the need for continuous evaluation of current legislation around SUD privacy/confidentiality is impacting patients. Recommend retention.
87	290.003MSS	Opposition to Medicaid Work Requirements	AMA-MSS will ask that our AMA oppose work requirements as a criterion for Medicaid eligibility.	Policy is still relevant. Recommend retention.
88	290.004MSS	Medicaid Coverage of Fitness Facility Memberships	AMA-MSS will ask the AMA to support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for low-income adult patients.	This policy supports Medicaid funding for fitness facilities, thereby improving physical health. Policy is still relevant. Recommend retention.

89	295.005MSS	Availability of Medical Education	AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service-obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools.	Internal policy that remains relevant. Recommend retention.
90	295.086MSS	Curriculum Mandates for Licensure	AMA-MSS will ask the AMA to urge state legislatures not to interfere directly with the medical school curriculum as it applies to licensure, leaving such matters to the appropriate accreditation bodies and medical school faculty.	Internal policy that remains relevant. Recommend retention.
91	295.111MSS	State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam	AMA-MSS will ask the AMA to: (a) commend the LCME for making clinical skill competencies a priority, (b) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and (c) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the	Internal policy that remains relevant. Recommend retention.

			matriculation requirements for the conferring of an MD degree.	
92	295.141MSS	Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students	(1) AMA-MSS will ask the AMA to recognize that inter-professional education and partnerships are a top priority of the American medical education system; (2) AMA-MSS will ask the AMA to explore the feasibility of the implementation of LCME and AOA accreditation standards requiring inter-professional training in medical schools.	This policy is relevant to medical school education and encourages recognition of the importance of interprofessional partnerships and the development of interprofessional medical education standards. Recommend retention.
93	295.142MSS	Communication and Clinical Teaching Curricula	(1) AMA-MSS (a) supports the development of formalized medical teacher training for residents and attending faculty and (b) will ask the AMA to establish policy supporting the development of formalized medical teacher training for residents and attending faculty.	Internal policy that remains relevant. Recommend retention.
94	295.168MSS	Expansion of Medical Spanish in US Medical Schools	AMA-MSS will encourage the AAMC, LCME, COCA, and AOA to identify and evaluate existing ways that schools incorporate medical Spanish and other non-English languages into their curricula and report successful strategies for improved proficiency to be used as guidelines for US accredited medical schools.	Internal policy that remains relevant. Recommend retention.
95	295.169MSS	Eliminating Legacy Admissions	AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the AACOM to remove any questions on secondary applications pertaining to legacy status.	The MSS has not passed a more recent policy that contradicts or is in opposition to this policy. Recommend retention.

96	295.170MSS	Supporting Two-Interval Grading Systems for Medical Education	AMA- MSS acknowledges the benefits of a two-interval grading system in medical colleges and universities for the non-clinical curriculum.	Internal policy that remains relevant. Recommend retention.
97	295.171MSS	Health Policy Education in Medical Schools	(1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and (2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies.	Internal policy that remains relevant. Recommend retention.
98	295.172MSS	Insurance Education for Medical Students	AMA-MSS will ask the AMA to work with the AAMC, AACOM, LCME, and COCA to encourage integration of medical educational curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician's role in obtaining affordable care for patients.	Internal policy that remains relevant. Recommend retention.
99	295.173MSS	Policy and Advocacy Rotations for Medical Students	AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies.	Internal policy that remains relevant. Recommend retention.
100	295.192MSS	Medical Student Involvement	AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and	Internal policy that remains relevant.

		and Validation of the Standardized Video Interview Implementation	its partners to assure that medical students and residents are recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and (2) advocate for delaying expansion of the Standardized Video Interview until published data demonstrates the efficacy and utility of the Standardized Video Interview as a mandatory residency application requirement.	Recommend retention.
101	295.193MSS	Implicit Bias and Its Effects on healthcare and Its Incorporation into Undergraduate Medical Education	AMA-MSS (1) recognizes the existence of implicit bias among health care clinicians; (2) recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and (3) supports medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients.	This policy remain relevant to our Section. Recommend retention.
102	295.194MSS	Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum	AMA-MSS (1) recognizes that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation.	This policy establishes an important position for the MSS that will remain relevant for many decades. Recommend retention.
103	305.043MSS	Tax Exemption	AMA-MSS supports federal legislation that will assure that	Internal policy that remains relevant.

		for National Health Service Corps Scholarship	tax-exempt status is returned to the direct medical school expense portion of the National Health Service Corps Scholarship program.	Recommend retention.
104	305.060MSS	Solutions to Tackling the Increasing Cost of Medical Education	AMA-MSS will ask the AMA to (a) support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students; and (b) support policies that ensure that all information related to the allocation of funds from tuition and fees increases be disclosed to all prospective and current medical students for each respective medical school campus; (2) AMA-MSS will work to develop print and electronic resources for our local chapters to utilize on their campuses to encourage their medical school deans to adopt policies that ensure transparency in medical school tuition and fees increases; (3) The AMA-MSS Governing Council will (a) continue to work with our AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), and the AAMC Organization of Student Representatives (OSR) to encourage medical schools to adopt policies that ensure that all increases to medical school tuition and fees go towards direct improvements to medical student education.	Internal policy that remains relevant. Recommend retention.
105	305.061MSS	Student Loan Empowerment	AMA-MSS will ask the AMA to support legislation that requires medical schools to inform students of all government loan opportunities along with private loans and requires disclosure of reasons that preferred lenders were chosen.	This policy remains relevant to our Section. Recommend retention.

106	305.077MSS	Increasing Public Service Opportunities for Specialists	AMA-MSS will ask the AMA to (1) encourage the National Health Service Corps and other relevant stakeholders to expand their scope and encourage the participation of specialists in order to ensure the provision of services in underserved communities; (2) work with state and federal governments, medical schools, the AAMC, and other relevant entities to encourage new loan forgiveness programs for specialists treating underserved patient populations; and (3) that our AMA urge states who opt-out of the ACA expansion of Medicaid to still comply with the increased reimbursement schedule for specialists treating Medicaid patients.	Language remains relevant. Third clause about Medicaid reimbursement was not adopted by HOD. Recommend retention.
107	305.083MSS	MSS Financial Burden of Application to Medical School and Residency	The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles: 1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives. 2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy	This issue remains relevant. Recommend retention.

			of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area.	
108	305.084MSS	Medical School Tuition	The AMA-MSS supports the following principles regarding medical school tuition: 1. That the AMA-MSS joins the AMA in its opposition of mid-year	Internal policy that remains relevant. Recommend retention.

			and retroactive medical school tuition and retroactive medical school tuition or fee increases and encourages collaborations in this oppositions, including the AAMC. 2. That the AMA-MSS will ask the AMA to study, in collaboration with state, specialty, and other interested organizations, the case precedent, timing, risks, and other considerations in filing an application for injunctive relief to block retroactive or mid-year tuition increase. 3. That the AMA-MSS will encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases including, but not limited to, state subsidies to public and private medical schools within their state. 4. That the AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class. 5. That the AMA-MSS	

			joins the AMA in its opposition of medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity. That the AMA-MSS will ask the AMA to discourage U.S. medical schools from requiring accepted international students to pay more than a single term's tuition at each billing period, in the same manner as the rest of the U.S. citizens and permanent U.S. residents within the student body.	
109	305.085MSS	Medical Students Federal Loans	The AMA-MSS supports the following principles regarding federal loans and taxation: 1. The AMA-MSS supports actively lobbying for legislation aimed at establishing an affordable student loan structure with a variable interest capped at no more than 5.0%. 2. The AMA-MSS supports and will ask the AMA to support government-sponsored in-school loan interest subsidies should be maintained. 3. The AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate. 4. The AMA-MSS will ask the AMA to lobby for passage of legislation that would (1) eliminate the cap on the student loan interest deduction, (2) increase the income limits for taking the interest deduction, (3) an	Internal policy that remains relevant. Recommend retention.

			increase to annual and aggregate loan limits to better reflect the true cost of medical education at the student applicant's medical school, (4) include room and board expenses in the definition of tax-exempt scholarship income. 5. The AMA-MSS will ask the AMA to support legislation that does not require medical students attending school full-time twelve months per year to provide summer earnings allowances as partial fulfillment of their loan requirements. 6. The AMA-MSS will ask the AMA to lobby for passage of legislation that would make permanent the education tax incentives that our AMA successfully lobbied for as part of the Economic Growth and Tax Relief Reconciliation Act of 2001. 7. The AMA-MSS will ask the AMA to oppose legislation that would allow medical school scholarships or fellowships to be subject to federal income or social security taxes (FICA). The AMA-MSS will encourage members to write letters to senators and representatives, especially those on the appropriate specific subcommittees, to support the visitation of the issue of how interest rates on student loans are determined and will provide a sample letter of support for this	

			cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.	
110	305.087MSS	Voluntary Service-Payback and Loan Repayment Programs	The AMA-MSS supports the following principles regarding voluntary service-payback and loan repayment programs: 1. The AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas. 2. The AMA-MSS will ask the AMA to advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.	This continues to be an important and relevant advocacy topic. Recommend retention.
111	305.088MSS	Increasing Availability and Access to Financial Aid	The AMA-MSS supports the following principles regarding access to student loans and availability of financial aid and scholarship monies: 1. That the AMA-MSS will ask the AMA to ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a	Our current policy remains relevant. Recommend retention.

			choice of funding to students. 2. That the AMA-MSS will ask the AMA to recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite, term. 3. That the AMA-MSS will ask the AMA to work with state medical societies, associated foundations and medical schools to ensure that information about all offered scholarships is readily available online. 4. That the AMA-MSS will ask the AMA to encourage societies to support further expansion of state loan repayment programs, and expansion of those programs to cover physicians in non-primary care specialties. 5. That the AMA-MSS will ask the AMA to urge each state medical society strongly to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body in addition to collecting and propagating bylaw changes from state societies that have added a medical student vote to their Board of Directors. 6. That the AMA-MSS will ask the AMA to urge, via its component state	

			medical societies, all state foundations to consider converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversion. 7. That the AMA-MSS will ask the AMA to request that the state foundations and the AMA Foundation encourage donors to pool their funds with others to endow large scholarships. 8. That the AMA-MSS will ask the AMA to request that the AMA Foundation work with state medical societies and their foundations to (1) make scholarship programs direct-application at the medical school level, (2) ensure that scholarship funds are disbursed directly to the student, not to the medical school. 9. That the AMA-MSS will ask the AMA to request that the AMA Foundation compile and distribute to the state foundations a list of fundraising "best practices" that have been shown to be effective in raising funds for medical scholarships.	
112	305.089MSS	Medical Student Debt Manageme	The AMA-MSS supports the following principles regarding financial management and	Our current policy remains relevant. Recommend retention.

		nt Education	debt education of medical students: 1. That the AMA-MSS will ask the AMA to encourage medical school financial aid offices to educate medical students in medical debt management and provide financial and tax counseling. 2. That the AMA-MSS will ask the AMA to assist medical school financial aid offices in implementing debt management, financial, and tax counseling and education services. 3. That the AMA-MSS will encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation. 4. That the AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants. 5. That the AMA-MSS ask the Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical colleges to provide additional data to	

			students and applicants including by not limited to: (1) average debt incurred in medical school for graduation students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles, (2) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution.	
113	305.090MSS	Medical Student Loan Forgiveness	The AMA-MSS supports the following principles regarding student loan forgiveness: 1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students. 2. That the AMA-MSS will ask the AMA to oppose the reduction and support that expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness. 3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including, but not	Our current policy remains relevant. Recommend retention.

			limited to, the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency.	
114	310.019MSS	Notification of Interview Decision to Residency Program Applicants	AMA- MSS will ask the AMA to strongly encourage residency programs to inform applicants in a timely manner about their interview status and provide a time frame of notification dates in the application materials.	Our current policy remains relevant on this issue. Recommend retention.
115	310.020MSS	Restrictive Covenants in Training Programs	AMA-MSS strongly supports the removal of restrictive covenants from residency and fellowship programs.	This policy remains relevant, particularly given recent FTC rulemaking on the issue. Recommend retention.
116	310.021MSS	Promoting Resident Involvement in Organized Medicine	AMA-MSS encourages residency programs across the country to permit and schedule off- duty time separate from personal vacation time to enable residents to attend educational and organized medicine conferences.	This policy will continue to remain relevant and retains an important role in advocating for residents. Supporting residents in engaging in organized medicine conferences is an important aspect of encouraging the pursuit of leadership, scholarly activities, and continued learning. There are still active barriers to resident involvement that we should be able to work to decrease in order for them to stay involved. Recommend retention.
117	310.030MSS	Resident/Fellow Work and	AMA-MSS supports the following general principles regarding resident/fellow duty hours to	Our current policy remains relevant.

		Learning Environment	promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four- week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important to patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) The Joint Commission should create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) The Joint Commission should establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; (11) The AMA Council	Recommend retention.

			on Legislation should serve as the coordinating body in the creation of legislative and regulatory options.	
118	315.002MSS	Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals	AMA-MSS supports added safeguards, such as audits or “break the glass” access, for medical student records when those records are placed in the same system used for patients at the school’s affiliated hospitals.	Safeguards to protect student's personal medical records at their institutions will help uphold the AMA's stance on medical students (and physicians) having the same right to privacy as other patients. Recommend retention.
119	315.007MSS	Integration of Drug Price Information Into Electronic Medical Records	Our AMA-MSS will ask the AMA to (1) support the incorporation of estimated patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden; and (2) collaborate with invested stakeholders, such as physician groups, Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden.	Internal policy that remains relevant. Recommend retention.
120	345.014MSS	Co-Location of Behavioral Health Care and Primary Care	AMA-MSS supports the co-location of behavioral health services within primary care clinics and other locations where primary care services are provided.	Internal policy that remains relevant. Recommend retention.
121	345.016MSS	Reducing the Use of Restrictive Housing in Prisoners with Mental Illness	AMA-MSS will ask the AMA to (1) oppose restrictive housing for incarcerated persons with mental illness and (2) encourage appropriate stakeholders to continue to develop and implement alternatives to restrictive housing for incarcerated persons with mental illness in all correctional facilities.	This policy remains relevant. Recommend retention.

122	350.013MSS	Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations	AMA-MSS will ask the AMA to encourage the National Institutes for Mental Health (NIMH) and local health departments to examine national and regional variations in psychiatric illnesses among immigrant and minority populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations.	This policy asks the AMA to encourage the NIH and local health departments to examine regional and national variations in psychiatric illnesses for minority and immigrant populations. In addition, it encourages the creation of mental health screening assessment tools that are validated in minority and immigrants. This policy is still relevant. The Covid-19 pandemic has exacerbated health disparities and mental health conditions. The MSS has not passed any more recent policy in opposition. Recommend retention.
123	350.016MSS	Improving Medical Care in Immigration Detention Centers	AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from	Internal policy remains relevant. Recommend retention.

			partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care.	
124	350.017MSS	Disaggregation of Data Concerning the Status of Asian-Americans	AMA- MSS will ask that our AMA support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.	Policy remains relevant. Recommend retention.
125	350.018MSS	Defense of Affirmative Action	AMA-MSS will ask the AMA to oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.	This policy asks the AMA to oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. This issue is as important as ever. With several lawsuits against affirmative action in the state and federal levels, our AMA's advocacy on this issue of equity and justice is of paramount importance. Recommend retention.
126	350.022MSS	Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities	AMA-MSS will ask the AMA to (1) advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations; (2) work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not	Internal policy remains relevant. Recommend retention.

			occur; (3) encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) oppose the presence of U.S. Immigrations and Customs Enforcement (ICE) at healthcare facilities.	
127	360.001MSS	Increasing the School Nurse to Student Ratio	AMA-MSS will ask the AMA to (1) encourage state medical societies and organizations, such as the National Association of School Nurses and other stakeholders, to advocate at all levels for adequate funding of school nurse positions; and (2) encourage public schools, private schools, and other relevant organizations to employ school nurses in a manner that complies with CDC recommended nurse-to-student ratios.	Policy is still relevant. Recommend retention.
128	370.003MSS	Organ Donors and Transplants	AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool.	The resolution's ask for public service announcements has not been accomplished by the AMA. Recommend retention.
129	370.011MSS	Investigating the Possibility of a Unified Living Donor Kidney Registry	AMA-MSS will encourage the AMA to support the study of how to develop a unified, nationwide living kidney donor registry and advocate for public and private funding of such studies to reach the long-term goal of establishing a unified registry.	This policy asks the AMA to support studying how to develop and advocate for funding for a living kidney donor registry. AMA policy H-370.960 "UNOS Kidney Paired Donation Program" encourages the expansion of the UNOS living kidney donor registry but does not support funding efforts.

				Recommend retention.
130	370.012MSS	Organ Donation Education Programs in Driver Training Programs	AMA- MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs.	Current AMA Policy, including H-370.995, H-370.959, H-370.984, and H-370.996 recognizes the importance of increasing the organ donor pool via public education and donor recruitment. While these policies broadly support education to potential donors, none specifically target the audience that this policy targets: people undergoing drivers' education, which could represent an important population to provide educational materials about organ donation. Recommend retention.
131	370.018MSS	Protecting Equity in Access to Kidney Dialysis and Transplant and Advocating for Patients' best Interest in End Stage Renal Disease	AMA-MSS supports evidence-based patient education and counseling regarding the relative risks and benefits of all treatment options for end-stage renal disease, including various types of dialysis and organ transplantation.	There has been no recent policy that opposes this policy. This policy is asking AMA-MSS to take a position which could help influence HOD policy. Recommend retention.
132	405.006MSS	Non-Compete Clauses in Physician Contracts	AMA-MSS opposes the use of restrictive covenants in physician contacts and supports the passage of laws that prohibit their use.	With ongoing restrictive covenants in physician contracts being utilized, this policy is still relevant and there is the potential for new legislation to be

				introduced in the future for the AMA and AMA-MSS to support in regard to opposing restrictive covenants. Further, the FTC is engaging in active rulemaking on this issue. Recommend retention.
133	420.005MSS	Inclusion of Folic Acid Supplements in the Supplemental Nutrition Program	AMA-MSS will ask the AMA to (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs.	This policy asks the AMA to support the addition of folic acid to various nutrition assistance programs through working with various federal organizations. AMA policies H-440.898 and D-150.985 encourage the FDA to fortify foods with folic acid, but do not specifically address this need in nutritional assistance programs. The policy topic is still relevant. Recommend retention.
134	420.010MSS	Infertility and Infertility Insurance Coverage	AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons.	This policy specifically asks for efforts studying trends of infertility and support insurance coverage of minorities. No current policy contradicts or replicates these goals. These efforts are still relevant. Recommend retention.
135	435.008MSS	Error Disclosure and Physician Apologies	AMA-MSS supports (1) full disclosure of medical errors; and (2) legislation that allows a physician to make an expression of apology, regret, sympathy, commiseration, condolence, or	The MSS has not passed a more recent policy that contradicts this policy and it remains relevant.

			compassion to a patient or a patient's family without it constituting an admission of physician liability for any purpose.	Recommend retention.
136	440.017MSS	Reducing the Risk of Flight-Associated Venous Thromboembolism	AMA- MSS will ask the AMA to work with and encourage the Federal Aviation Administration (FAA) and the airline industry to alert passengers to the flight-associated risk of deep vein thrombosis and to provide specific recommendations to passengers regarding ways to reduce their flight- associated risk for DVT.	AMA Policy D-45.998 states the AMA will monitor the relationship and research on DVT and air travel and will further encourage the FAA to enact comprehensive DVT prevention education to passengers of long flights. The policy is still relevant and actionable. Recommend retention.
137	440.018MSS	Childhood Obesity as a Public Health Epidemic	AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media-based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups.	This policy should be retained. Given the recent AMA letters emphasizing the importance of substantive action toward combating childhood obesity and a large body of AMA policy supporting the policy, the resolved clause of the policy remains relevant. Recommend retention.
138	440.039MSS	Support for Service Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership	AMA-MSS will ask the AMA to (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and	The MSS has not passed a more recent policy that contradicts or is in opposition to this policy. This policy does not amend HOD policy. Recommend retention.

			handicaps when expert opinion and the scientific literature show a potential benefit.	
139	440.042MSS	Permitting Sunscreen in Schools	AMA-MSS will ask the AMA to (1) support the exemption of sunscreen from over-the-counter medication possession bans in schools and to encourage all schools to allow students to bring and possess sunscreen at school without restriction; and (2) encourage schools to allow teachers to provide students with sunscreen, without requiring the teacher to assist in application.	With recent AMA webpage publications emphasizing the importance of sun safety and sunscreen usage, the resolved clause of this policy remains relevant. Additionally, this MSS policy aligns with current AMA policy and is not contradicted by any MSS or AMA policy. Recommend retention.
140	440.062MSS	Addressing Foster Care Healthcare Needs	AMA-MSS will ask that our AMA advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children.	This policy topic remains relevant. Recommend retention.
141	440.063MSS	Recognizing Poverty-Level Wages as a Social Determinant of Health	AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health.	This policy asks the AMA to support efforts to address poverty level wages and is supported by multiple HOD resolutions and is an ongoing effort in the realm of public health. There is no recent policy which opposes this policy. Recommend retention.
142	440.064MSS	Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information	AMA-MSS will ask the AMA to (1) oppose policies that enable racial housing segregation and (2) advocate for continued federal funding of publicly accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not	Internal policy remains relevant. Recommend retention.

		Systems (GIS) Data	limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.	
143	440.065MSS	Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic	AMA-MSS will ask the AMA to 1) acknowledge HPV Vaccines as beneficial to all genders as anti-cancer and anti-STI; and (2) support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs.	Internal policy remains relevant. Recommend retention.
144	440.066MSS	Opposition to Measures That Criminalize Homelessness	AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting, or sleeping in public spaces; and (2) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights.	This policy asks the AMA to take a position in opposition to the criminalization of homelessness. This remains relevant. Recommend retention.
145	440.067MSS	Food and Drug Administration Conflict of Interest	AMA-MSS will ask the AMA to (1) advocate for a reduction of conflict-of-interest waivers graded to Advisory Committee Candidates, and (2) advocate the Food and Drug Administration place a greater emphasis on candidates' conflict of interest when selection members for advisory committees	This policy asks that the AMA advocate for a reduction of conflict of interest in selecting FDA advisory committee members. Additional AMA policy encourages a strong relationship with the FDA, so ensuring that advisory committee members are credible and deserving of public trust is essential. This policy remains relevant. Recommend retention.
146	440.068MSS	Support for Public	AMA-MSS will ask the AMA to support legislation in addition to	Although the HOD and MSS have

		Health Violence Prevention Programs	other mechanisms that encourage the development and use of evidence-based public health models that prevent violence.	numerous policies detailing AMA support for specific public health violence prevention, there is currently no policy covering such support for evidence-based public health violence prevention models in general. Thus, the policy remains relevant. Recommend retention.
147	440.075MSS	Support for Research of Boxes for Babies Sleeping Environment	AMA-MSS will ask the AMA to support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States.	This policy asks the AMA to support the research of safe sleeping environment programs and gives an example of the "boxes for babies" program. The goal of this resolution to investigate potential initiatives or government programs that could reduce SIDS in the United States. This resolution was passed in 2013 and reaffirmed in 2017. Given that SIDS is still a very real problem across the United States, this resolution is still relevant. Moreover, further advocacy could be done in this area, especially within underserved communities. Recommend retention.
148	440.079MSS	Medical Respite Care for	AMA-MSS will ask the AMA to study funding, implementation, and standardized evaluation of	Does not conflict with AMA or AMA-MSS policy and more

		Homeless Adults	Medical Respite Care for homeless persons.	action needs to be done to complete this task. Recommend retention.
149	440.080MSS	Ending Money Bail to Decrease Burden on Lower Income Communities	AMA-MSS will ask the AMA to support legislation that ends pre-trial financial release options for individuals charged with non-violent crimes.	This policy remains relevant. Recommend retention.
150	460.020MSS	Reintroduction of Mitochondrial Donation in the United States	AMA-MSS will ask the AMA to support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases to at-risk males.	Given the lack of high-quality research since the passage of this policy, and no AMA correspondence encouraging ongoing research, this policy remains relevant. Recommend retention.
151	460.021MSS	Researching Drug Facilitated Sexual Assault Testing	AMA-MSS will ask the AMA to study the feasibility and implications of offering drug testing at point of care for date rape drugs, including but not limited to rohypnol, ketamine, and gamma- hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault.	Our current policy remains relevant. Recommend retention.
152	480.010MSS	Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship	AMA-MSS (1) supports our AMA urging the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and	There are related policies regarding the stance of AMA in regard to telehealth regulations and initiatives, but none are directed at the actions of the Department of Health and Human Services. This policy works synergistically with current policies and remains relevant. Recommend retention.

			regulations; and (2) supports our AMA seeking regulatory guidance from the DHHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services.	
153	480.011MSS	Use of Integrated Pre-hospital Electronic Patient Care Reports for Pre-hospital Healthcare Providers	AMA-MSS will ask the AMA to support legislation incentivizing the comprehensive use of integrated electronic patient care reports by EMTs and paramedics for better cross communication, and to standardize the flow of information from pre-hospital to hospital.	This has yet to become HOD policy, and our MSS has no contradictory policies. The topic remains relevant. Recommend retention.
154	480.012MSS	Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology	AMA-MSS supports increasing the number of funded positions at all levels of graduate, medical, and allied health professional training in medical informatics to a level commensurate with current Health Information Technology (HIT) spending through mechanisms including, but not limited to, student research positions funded by National Institutes of Health (NIH) T and F programs.	This policy remains relevant. Recommend retention.
155	490.017MSS	Smoking Around Public Buildings	AMA-MSS will ask the AMA to encourage state and local legislation prohibiting smoking around the entrances to any building in which smoking is prohibited.	The spirit of this resolution is to prevent undue second-hand smoke in public places. No recent policy was found to contradict this policy. Recommend retention.
156	500.004MSS	Picture-Based Warnings on Tobacco Products	AMA-MSS will ask the AMA to support appropriate legislation requiring picture-based warning labels on tobacco products produced in, sold in or exported from the United States.	The policy remains relevant given tobacco's continued. The policy aligns with current AMA policy and has not been contradicted by any

				recent AMA or MSS policy. Recommend retention.
157	515.005MSS	Protection of the Privacy of Sexual Assault Victims	AMA-MSS will ask the AMA to condemn the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim.	The MSS has not passed any contradictory policy. The MSS has passed a number of new policies related to sexual assault and services for sexual assaults victims, but none of those policies mention protections of privacy for sexual assault victims. Policy is still relevant, recommend retention.
158	515.008MSS	The Identification and Protection of Human Trafficking Victims	AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking.	The asks are still relevant and novel. Despite several new policies strengthening the need for advocacy surrounding human trafficking, there has been limited AMA efforts on this topic. Recommend retention.

159	515.010MSS	Sexual Assault Survivors' Rights	AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors' rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.	The asks are relevant and have not been contradicted. Recommend retention.
160	515.011MSS	Increased Use of Body-Worn Cameras by Law Enforcement Officers	AMA- MSS will ask that our AMA advocate for legislative, administrative, or regulatory measures to expand funding for (i) the purchase of body-worn cameras and (ii) training and technical assistance required to implement body- worn camera programs.	There has been no additional policy on this topic. While a letter was sent to Congress stating the AMA's support for body-worn cameras by law enforcement officers, there is no indication that additional action has been taken to create policy regarding privacy concerns for law enforcement

				wearing body-worn cameras in healthcare settings. Further, the topic remains relevant. Recommend retention.
161	515.012MSS	Collecting and Releasing Data on Law Enforcement Use of Force	AMA-MSS supports the collection of data by the CDC and state departments of health on serious law-enforcement-related injuries and deaths and supports making law-enforcement-related deaths a notifiable condition.	This policy is still relevant, considering the current epidemic of police brutality. No prior policy exists on the part of AMA regarding this topic, reinforcing the need to maintain 515.012MSS for the furthering of institutional transparency in social justice goals. Recommend retention.
162	525.010MSS	Support for VA Health Services for Women Veterans	AMA-MSS recognizes the specific healthcare needs of the growing population of women veterans.	This policy forms the foundation of support for female veterans for future policy to expand upon and it has not been replaced by current policy. Recommend retention.
163	530.012MSS	Product Endorsements	AMA-MSS supports policy whereby the AMA shall not endorse any products or services produced by other companies and marketed to consumers unless approved by the Board of Trustees, with no endorsements being made on an exclusive basis.	Still relevant. Recommend retention.
164	630.074MSS	Review of AMA-MSS Statements of Support of HOD Policies	(1) The formally- supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions	This policy is actively being reconsidered by the Resolution Task Force and recommendations pertaining to this amendment/actionability are being developed.

			every five years for redundant and outdated statements of support.	Recommend retention so as to defer to the Resolution Task Force for final determination on this policy.
165	640.014MSS	Regional Representation on MSS Committees	The AMA-MSS Governing Council will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees.	This policy plays an important role in increasing medical student membership and engagement in AMA-MSS leadership. It takes into consideration variations in regional processes and needs. Recommend retention.
166	645.012MSS	Health Policy Programming	The AMA-MSS Governing Council will continue to identify ways to incorporate educational opportunities in health policy into the national meeting structure as appropriate.	Educational Programming is organized at each meeting and therefore this policy remains relevant. Recommend retention.
167	645.019MSS	European Medical Student Association (EMSA) – Official Observer	The AMA-MSS will invite the European Medical Students Association to send a non-voting Official Observer to all meetings of the AMA-MSS Assembly.	This policy remains relevant as long as the AMA-MSS Assembly continues to hold meetings. Recommend retention.
168	645.034MSS	Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates	AMA-MSS will study the outcomes of MSS resolutions in the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures of the degree to which MSS goals were met regardless of outcome. The AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate, consider using the results of the study to continue to improve and update the resolution writing process and report back to the MSS	This policy may be considered by the RTF report. Recommend retention here so as to defer to their recommendations.

			Assembly at intervals deemed appropriate by the AMA-MSS Governing Council.	
169	655.018MSS	Membership Retention into Residency	AMA-MSS will continue to explore ways to increase awareness of the Medical Student and Resident Fellow Sections in order to increase membership retention during the transition to residency.	This policy is still relevant to membership recruitment and retention in the AMA. Recommend retention.
170	655.025MSS	Increasing the Efficiency of Student Membership Application Processing	AMA-MSS encourages the AMA to continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members.	This policy is still relevant and no more recent policy has been passed on the matter. The policy asks the AMA to continue evaluating procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members. This policy is important for ongoing quality assurance of internal AMA procedure. It is a broad statement advocating for efficient student membership application processing. Recommend retention.
171	660.017MSS	Campaign Reform	AMA-MSS encourages all members to recognize the commitments of the candidates at the Interim and Annual meetings and use prudent judgment when inviting them to address group meetings and furthermore strive for fair and equal access to all candidates and all sections, states, and societies.	This policy remains relevant to ensure fair treatment of all candidates and increase the efficacy of each election. Recommend retention.

1

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report B
(A-23)

Introduced by: Ryan Englander, Section Delegate; Brittany Ikwuagwu, Section Alternate Delegate; Kylie Rostad, Laurie Lapp, Rajadhar Reddy, Sarah Mae Smith, Justin Magrath, Jack Gatti, Revati Gummaluri, Allie Conry, Jenna Gage, Resolution Task Force

Subject: Report of the 2023 Resolution Task Force

Referred to: MSS Reference Committee
(Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 2022 Annual Meeting of the AMA Medical Student Section (MSS), the MSS Governing Council (GC) produced a report (GC Report B) to update the MSS Assembly on the implementation of the 2018 Resolution Task Force recommendations to improve the MSS policy making progress. The recommendations of GC Report B were as follows:

RESOLVED, That the original recommendations of the 2018 AMA-MSS Resolutions Task Force continue to be upheld, implemented, or supplemented as follows:

~~Pilot Implementation of the 2018 Resolution Task Force Recommendations~~ Ongoing Implementation of MSS Resolution Process Reforms 630.075MSS

MSS will:

1. Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and b) ~~Making a~~ Maintaining videos and "cheat sheets" explaining the basics of Parliamentary Procedure and the most common mistakes made;
2. Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee;

3. Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring that ~~all~~ external resolutions ~~authors to contact~~ be sent to the relevant specialty society ~~prior to~~ submission to the MSS Assembly to receive input for consideration by the Reference Committee;

4. Improve transparency of resolution feedback among all actors throughout the AMA-MSS Digest of Policy Actions/ 298 resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers' ~~to send~~ feedback summary emails to be sent to the primary author's Region Chair and Region Delegation Chari in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;

5. Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC;

6. Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category;

7. Reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores;

8. Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its

rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; ~~and~~

9. Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC, HOD Reference Committee Team Leads, and Regional Delegation Chairs and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year~~.~~;

10. Continue creating a process by which Standing Committee reports undergo review in a similar manner to the resolution review process;

11. Continue a trial period of virtual extractions from the Reference Committee Report for future in-person meetings and report on the satisfaction and outcomes of this process to the Section;

12. Work with relevant stakeholders including relevant AMA-MSS Standing Committees, AMA liaisons, partner medical student organizations, the AMA Center for Health Equity, and others to continue building more permanent processes by which our AMA-MSS can better evaluate its resolutions for their impact on equity; and

13. Continue investigating methods to improve institutional memory, including potentially a system of guides required from AMA-MSS original authors whenever their resolution is adopted to be sent to the AMA HOD.

and be it further

RESOLVED, That these changes, and the AMA-MSS resolutions process as a whole, will be re-evaluated in an AMA-MSS Governing Council report to be presented 5 years after the adoption of these recommendations.

GC Report B was referred for study in order to allow opportunities for increased input and engagement from across the MSS. The GC voted to reconstitute the Resolution Task Force to provide input on the recommendations from GC Report B and make any additional recommendations necessary to improve the MSS policy making process. Specifically, the GC assigned the Resolution Task Force the following objectives:

1. Review the recommendations from the A-22 GC Report B, including the rationale provided in the report, associated VRC commentary, and any other relevant or pertinent information; and
2. Clarify the role of HCC in the MSS policy process, specifically:
    a. Whether the reaffirmation calendar ought to continue to be an HCC responsibility; and
    b. Whether HCC should be under the purview of the Vice Chair or the Section Delegates; and
3. Review the mechanism whereby external reaffirmations result in “statements of formal support” as detailed in 630.037MSS, including:

a. Whether this process accurately reflects the will of the Section; and
b. How this process impacts the MSS Policy Digest, including its length and readability; and
c. The relative strengths and weaknesses of other mechanisms to handle external reaffirmations in the MSS Policy Digest; and

4. Report formal recommendations back to the MSS Governing Council prior to the opening of the Virtual Reference Committee.

This report will detail the recommendations of the Resolution Task Force and the rationale that led to its recommendations.

BACKGROUND

In 2018, the original MSS Resolution Task Force (2018 RTF) provided recommendations to the GC to improve the quality of resolutions presented to the MSS Assembly. Those recommendations led to the passage of "Pilot Implementation of the 2018 Resolution Task Force Recommendations 630.075MSS", which became one of several policies that provided guidelines for the MSS resolution review process. The modern MSS policy process is largely set by the Section Delegates in consultation with the GC, AMA-MSS staff, and relevant stakeholders throughout the MSS including Regional leadership and standing committees, and proceeds through several key stages:

Open Forum

The AMA-MSS policy process begins with the Open Forum, where prospective resolution authors post their ideas to facilitate collaboration and feedback prior to draft resolution submission. The Open Forum generally opens about two months after the conclusion of the prior national meeting (either Interim or Annual) and concludes approximately one month after opening. Authors must post on the Open Forum prior to its closure in order to continue through the standard resolution writing process.

AMA-MSS Section Delegates (SDs) review these Open Forum posts to determine if posts meet minimum eligibility requirements (i.e., that posts not be blank) and organize review processes. Past review process have relied on the Regional Delegation Chairs (RDCs) to organize review of Open Forum posts; in the most recent A-23 policy cycle, SDs have specifically assigned Region Delegates/Alternate Region Delegates (RDs/ADs) to review Open Forum posts and provide feedback on impact, novelty, evidentiary support, resolution alternatives, and any other relevant considerations. The House Coordination Committee (HCC) also independently organizes review of Open Forum posts with a focus on whether ideas are novel relative to existing MSS and AMA policy.

In a typical cycle, 150-200 eligible ideas are posted to the Open Forum; the A-23 cycle saw a record 265 eligible ideas posted to the Open Forum.

Resolution first drafts

Resolution first drafts are submitted through a Google Form provided to Open Forum post authors. In order to submit their resolution, authors must certify they have completed the requirements of the Draft Resolution Checklist, which generally requires that authors have reviewed relevant MSS and AMA policy, resolution alternatives, AMA advocacy actions, and understand the additional requirements that will need to be fulfilled later in the process. In the A-23 cycle, SDs also required authors to respond to the feedback provided by their Open Forum post RD/AD reviewer.

Resolution drafts are blinded by the AMA-MSS Policy Analyst, and are assigned by the SDs to RD/ADs for review. Each draft resolution is assigned three RD/ADs, including two secondary

reviewers who provide detailed feedback on all aspects of the resolution and one primary reviewer who provides additional comments and summarizes all feedback left on the draft. Additionally, the SDs, with feedback from the Vice Chairs, standing committees, Councilors, and liaisons to AMA Sections, specialty societies, national medical student organizations (NMSOs), professional interest medical associations (PIMAs), etc., assign standing committees, Councilors, and liaisons to review draft resolutions. A member of the HCC also provides detailed feedback on the novelty of the draft resolution, including whether the resolution is likely to be recommended for reaffirmation. These resources are collated by SDs and sent to draft resolution primary authors.

Typically, approximately 90-120 eligible first drafts are submitted. For the A-23 cycle, 132 eligible first drafts were submitted.

Final resolutions

Similar to the first draft stage, resolution primary authors are required to submit final resolutions through a Google Form that is provided to eligible draft resolution primary authors. In order to submit their final resolution, authors must certify they have completed the requirements of the Final Resolution Checklist, which generally requires that authors have considered and responded to feedback, reviewed relevant MSS and AMA policy, resolution alternatives, AMA advocacy actions, understand the future components of the MSS resolution process (including the Virtual Reference Committee and extraction process), and recognize that final resolutions become MSS property once posted on the Virtual Reference Committee. Furthermore, the final resolution submission form asks authors of external resolutions to identify specialty societies and/or AMA Sections whose feedback would be useful for the MSS Assembly. SDs then coordinate with AMA-MSS staff to send final resolutions to the indicated specialty societies/AMA Sections for review.

Authors can also choose to submit their resolutions for sponsorship by AMA-MSS Regions and NMSOs, according to processes delineated by these specific groups. If any of these entities choose to sponsor a resolution, they are listed as resolution sponsors on the header of the resolution.

Traditionally, final resolutions are scored by RD and ADs. In some cycles, HCC members help score resolutions as well. Resolutions are scored on the basis of clarity (10 points), research (30 points), novelty (25 points), timeliness (10 points), scope/feasibility (15 points), focus (10 points), response to feedback (5 points), and sponsorship by AMA-MSS Regions/national medical student organizations (NMSOs) (5 points). Resolution scoring closes prior to the opening of the Virtual Reference Committee (see below). These scores have been used to determine the ranking of items in the order of business. For the A-23 cycle, final scoring was not conducted; instead, resolutions were ranked by the order in which they were submitted.

Typically, anywhere from 60-90 eligible final resolutions are submitted. For the A-23 cycle, 90 eligible final resolutions were submitted.

Virtual Reference Committee

The Virtual Reference Committee (VRC) is an online Reference Committee that allows any AMA-MSS member to provide written testimony on eligible final resolutions submitted through the MSS resolution process. Generally, resolution authors, members of MSS Regions, standing committee members, Councilors, and members of the MSS Caucus including SDs participate in the VRC, though any MSS member may do so. In addition to AMA-MSS members, SDs may also post feedback from outside groups, including specialty societies, state medical societies, AMA Sections, and any other outside stakeholder who may wish to provide feedback on a given resolution. The MSS Government Relations and Advocacy Fellow (GRAF) may also post feedback from AMA advocacy staff. The VRC generally stays open for approximately two

weeks, after which time comments are sent to the Reference Committee for consideration.

Reference Committee

The MSS Reference Committee is composed of members of the MSS chosen by the MSS Speaker and Vice Speaker with input from the MSS Governing Council. The Chairs and Vice Chairs of the Reference Committee are also selected by the Speaker and Vice Speaker. The members of the Reference Committee review all resolutions, all comments left on the VRC, and any testimony from outside groups or stakeholders in the AMA who may provide feedback. The Reference Committee makes recommendations for each item, including “adopt”, “adopt as amended”, “adopt in lieu of”, “refer for study”, “reaffirm in lieu of”, or “not adopt” (see particular considerations associated with the “reaffirm in lieu of” motion in the “Reaffirmation Consent Calendar” section below). These recommendations are collated into the Reference Committee Report by staff, which contains the Reference Committee recommendations for each item alongside the Reference Committee’s rationale. This report is made public, generally 1-2 weeks prior to the MSS Assembly.

Reaffirmation Consent Calendar

The Reaffirmation Consent Calendar is the list of items recommended for reaffirmation in lieu of existing MSS or AMA policy. Per the current MSS IOPs, items recommended for reaffirmation can only be extracted from the consent calendar presented at the beginning of the MSS Assembly (see below) with a one third vote (all other items may be extracted without a vote). As instructed by Policy 630.075MSS, the Reaffirmation Consent Calendar is set by the House Coordinating Committee, a standing committee within the MSS.

In parallel to the review process conducted by the MSS Caucus with input from other stakeholders, members of HCC review resolutions for novelty, i.e., whether the resolution’s ask is already covered by existing MSS or AMA policy. HCC provides authors feedback as to whether their resolution ideas/resolve clauses are considered novel or may be reaffirmation at each stage of the resolution review process. Authors have opportunities at each stage to respond to their individual HCC reviewers and explain why they believe their resolution ideas to be novel. After final resolutions are submitted, HCC decides which items to place on the Reaffirmation Consent Calendar. These items are then recommended for reaffirmation in the Reference Committee Report.

In the A-22, I-22, and A-23 resolution cycles, the Reference Committee has interpreted 630.075MSS to permit the Reference Committee to remove an item placed on the Reaffirmation Consent Calendar if the Reference Committee devised amendments to the item that resolved the rationale under which HCC had originally placed the item on the Reaffirmation Consent Calendar. Prior to this re-interpretation, items could only be removed from the Reaffirmation Consent Calendar via MSS Assembly action.

MSS Assembly

At the MSS Assembly meeting, the Reference Committee Report is presented to the Assembly as a consent calendar. Any MSS member may extract items from the Reference Committee Report for discussion. The Assembly then adopts the remainder of the Reference Committee Report as a consent calendar and thus adopts the Reference Committee’s recommendations for the items that were not extracted. As noted above, items may be extracted from the Reference Committee Report by any member of the AMA-MSS without a vote or discussion, with the exception of items recommended for reaffirmation, which require a one third vote of the MSS Assembly to extract (MSS IOPs, Section 10.8.6).

During the virtual meetings held during the COVID-19 pandemic, the MSS instituted a Virtual Extraction Form that allowed authors to extract items from the Reference Committee Report

virtually. The use of the Virtual Extraction Form has continued after meetings returned to the standard in-person format. This form closed prior to the MSS Assembly meeting at N-20, J-21, N-21, and A-22. At the I-22 and A-23 meetings, the Virtual Extraction Form closed prior to the MSS Assembly, but MSS members could move to extract items in person with a majority vote of the MSS Assembly.

Following the adoption of the Reference Committee Report, the remaining extracted items are discussed in the order of business set by the MSS Speaker and Vice Speaker. The Assembly, presided over by the Speaker and Vice Speaker, discusses and decides the fate of each extracted item according to the American Institute of Parliamentarians Standard Code of Parliamentary Procedure. Items that are not discussed by the close of the MSS Assembly are not adopted.

Resolution Task Force

As detailed above, GC Report B was referred for study at A-22. Conversation on the VRC and in the Reference Committee Report highlighted a lack of input from stakeholders in the MSS in the development of the report's recommendations. To alleviate this concern and solicit the necessary feedback to conduct a robust review of GC Report B's recommendations and the broader status of the MSS policy process, the MSS Governing Council voted to constitute a Resolution Task Force composed of experienced MSS members from across the Section. The Charter of the Resolution Task Force is attached as Appendix A of this report.

Your Section Delegates, serving as Task Force Co-Chairs, selected seven applicants from across the MSS, prioritizing applicant experience in the MSS and House of Delegates (HOD), diversity of background and perspectives including Regional diversity, and familiarity with the MSS resolution writing and review process. Additionally, the Co-Chairs of HCC selected two members of HCC to serve on the RTF. All members of the RTF were approved by the MSS Governing Council.

The Task Force met four times for approximately two hours at each meeting to discuss the objectives assigned by the MSS Governing Council and develop its recommendations. The Task Force then held a 2.5 hour public town hall open to any MSS member in order to describe its deliberations and solicit feedback from members across the Section. Following this town hall, the Task Force discussed and finalized its recommendations, which were then forwarded to and approved by the MSS Governing Council. Both the Task Force and the MSS Governing Council approved the report and its associated recommendations unanimously.

DISCUSSION

The 2023 Resolution Task force (RTF) covered multiple broad yet overlapping aspects of the MSS resolution writing process. This section will be separated by general topic for clarity; however, these various components were discussed and considered by the Task Force together in an attempt to build a coherent structure for the final recommendations.

Recommendations of GC Report B-A-22

The RTF considered the recommendations of GC Report B to amend 630.075MSS, "Pilot Implementation of the 2018 Resolution Task Force Recommendations". Discussion highlighted that the existing language in 630.075MSS and proposed amendments in GC Report B are quite prescriptive, and furthermore, that 630.075MSS is only one of several policies that create requirements for how the MSS resolution writing process ought to be conducted (other relevant policies include: 630.007MSS, 630.008MSS, 630.016MSS, 630.037MSS, 630.051MSS, 645.023MSS, 645.031MSS, and 645.032MSS). The prescriptive nature of the requirements imposed by 630.075MSS and related policies, and the fragmented nature of these policies, was felt to make the job of running the resolution writing and review process unnecessarily

burdensome and less efficient, without meaningfully adding any additional value to the process overall. The RTF elected to rescind these policies (with the exception of 630.007MSS, the contents of which the RTF felt important to retain and which did not fit well with the spirit of the remaining policies) and replace them with a single omnibus policy (the "MSS Policy Process" policy) establishing clear guidelines for the MSS resolution writing and review process. The goal of the proposed policy is to provide Section Delegates, the MSS Caucus, and other stakeholders the flexibility to be adaptable while also ensuring a fair, equitable, and democratic policy deliberation process.

Determining the components of the MSS resolution writing and review process

The RTF noted that the MSS Internal Operating Procedures (IOPs) entrust responsibility for managing the resolution review process to the MSS Section Delegates (MSS IOPs, Section 4.4.3.4), and felt that providing them general guidelines and principles that they should abide by when structuring the process for each particular policy cycle would promote efficiency, provide clarity, and limit confusion. The RTF felt it important to specify that the Section Delegates should ensure that all items of business submitted for consideration at each MSS Assembly meeting be reviewed through a process that focuses on identifying each resolution's impact, feasibility, timeliness, and evidence basis. Novelty was specifically excluded from this list, as the RTF felt that novelty was inherently covered by impact and timeliness, and felt that focusing on the degree of impact that a given resolution would have, as opposed to whether a resolution was strictly novel or not, was a more meaningful consideration.

Furthermore, the RTF felt it important to specify that the resolution review process established by the Section Delegates provide opportunities for input by stakeholders across the MSS, AMA, and external partner organizations (for the full list, see the "Recommendations" section). The language recommended by the RTF will ensure that Section Delegates incorporate the perspectives of stakeholders from across the Section when planning for and implementing the resolution review process, while also ensuring that the Section Delegates have the flexibility to make final decisions regarding that process as best fits the needs of the Section. Finally, the RTF considered that Section Delegates have historically set the timeline for each policy cycle preceding the MSS Assembly, and decided that codifying that precedent in policy would promote clarity over which entity is responsible for setting the timeline for the resolution review process each cycle.

Establishing the structure and role of the Reference Committee

As a key player in the MSS policy process, the RTF felt that language should be included in the omnibus resolution writing and review process policy pertaining to the structure and role of the Reference Committee. The language proposed essentially reaffirms the historic structure of the MSS Reference Committee, its responsibilities, and the types of motions that it may recommend for items of business. Furthermore, the RTF felt it would maximize clarity to specify that the Reference Committee Report should follow a consent calendar format, as has historically been done. Finally, the RTF recommended specifying that the Section Delegates have the power to set the timeline and procedure for extracting items from the Reference Committee Report to codify existing precedent. The RTF considered whether to recommend specific guidelines for the extraction process, such as specifying a virtual and/or in-person component, but ultimately decided to provide the Section Delegates the flexibility to determine the extraction procedures that are in the best interest of the Section prior to each meeting of the MSS Assembly.

Resolution scoring and the order of business

The RTF noted that 630.075MSS specifies that the order of business of the MSS Assembly should be set according to quantitative resolution scores, which refers to the scores final resolutions generally receive (see "Background" section above, subsection "Final resolutions"),

and sets out a specific scoring rubric for doing so. Notably, 645.031MSS, "Policy-making Procedures", specifies a specific way in which Regional Delegates, Alternate Regional Delegates, and HCC members should be assigned to resolutions for rough draft and final resolution scoring; this specific procedure has not been followed since 2018. The RTF felt that resolution scores tend to be fairly arbitrary, with poor inter-rater reliability and relative weights for each score component that lack a clear rationale. The RTF also noted that, in the modern form of the MSS resolution writing and review process, subjective feedback on the components addressed by quantitative scores, including impact, evidentiary strength, timeliness, and political considerations, is often more specific, more precise, and more useful to authors than the quantitative score, which authors regularly find confusing and difficult to address.

Furthermore, with respect to the role of final resolution scoring in the order of business, the RTF noted that the goals of the current scoring system are at least partially redundant with the Reference Committee's deliberation process. When the scoring system achieves its purported goal, those resolutions with higher scores would tend to be recommended for adoption or adoption as amended in the Reference Committee Report, and thus be listed earlier in the order of business. Conversely, resolutions with lower scores would be assigned to Reference Committee Report recommendation categories that are listed later in the order of business (not adopt, reaffirm in lieu of, etc.). Thus, through a deliberation process that holistically considers a resolution's merits and testimony from MSS members and other stakeholders, the Reference Committee report at least partially establishes an agreeable order of business without a quantitative scoring process that has proven arbitrary in practice.

Finally, the RTF highlighted that resolution scoring is a significant amount of extra work for the MSS Caucus and HCC. Thus, the RTF recommends eliminating the use of final scoring as a mechanism to set the order of business. Accordingly, the RTF recommends eliminating specific references to quantitative resolution scoring in MSS policy, permitting Section Delegates the flexibility to decide whether quantitative scoring is a helpful adjunct to qualitative feedback during the resolution review process.

The RTF discussed alternative mechanisms to set the order of business. Proposed mechanisms included 1) randomizing the order of resolutions within each Reference Committee recommendation category and 2) setting the order within each Reference Committee recommendation category by the time at which the final resolution was submitted. The RTF elected not to pursue the latter option, as it could create a perverse incentive to submit final resolutions before they are ready. Instead, the RTF chose to recommend setting the order of business first by Reference Committee recommendation category, and then by randomizing resolutions *within* each Reference Committee recommendation category. Because the RTF generally felt that final scores were arbitrary and random, randomizing resolutions was felt to be closest to the system historically employed, and a fairer way to set resolutions.

Other components of the omnibus resolution writing process policy

The RTF, as noted above, felt it to be important to centralize all policies related to MSS resolution writing and review processes and procedures into one resolution. To that end, the RTF recommended combining language from existing MSS policy 1) prohibiting resolutions from being rejected from consideration solely due to content (630.007MSS) and 2) requiring that the MSS IOPs and Digest of Policy Actions be made available on the MSS website within 2 months of the last national meeting (630.051MSS) into the omnibus resolution writing process policy. The aforementioned policies were recommended for rescission as a result (see "Policies recommended for rescission" subsection below). Finally, the RTF recommended incorporating language into the omnibus resolution writing process policy from 645.031MSS requiring that a resolution template be made available to assist authors with formatting, so as to consolidate all policies pertaining to the resolution process into a single policy.

Additional MSS Caucus operations

During the discussion surrounding the omnibus resolution writing process policy, the RTF recognized that 645.023MSS, “Medical Student Section Policy Making Procedures”, gives the Section Delegates the power to forward MSS resolutions that were previously not adopted by the House of Delegates back to the House when the respective internal MSS policy is eligible to be sunset once every five years (for a more thorough discussion of the sunset mechanism, see “Reaffirmation” below). The RTF noted that strategic opportunities to get previously not adopted resolutions passed at the House of Delegates do not come at regular intervals once every five years, and may be short-lived when they do occur. Therefore, the RTF recommended that the Section Delegates should have the ability to nominate any policy to be re-forwarded to the House of Delegates at any time. Because the Assembly had by definition already passed the language and the strategic opportunity to see the will of the Assembly accomplished might not be long-lasting, the RTF decided against requiring that the Section Delegates bring their recommendations to the MSS Assembly for approval, which would require at least a 6 month delay between nomination and transmittal. Instead, the RTF felt that the MSS Caucus, which could respond to the Section Delegates’ nominations quickly, already had insight into the strategic environment in the House of Delegates, and were entrusted by the MSS to represent the Section in the House of Delegates, was a more appropriate body to approve or deny the Section Delegates’ nominated items.

Additionally, the RTF noted that nowhere in the MSS IOPs or the MSS Digest of Policy Actions is the procedure for co-sponsorship of resolutions in the AMA House of Delegates specified. The RTF felt that specifying a general procedure for an action with such potentially profound implications for MSS resolutions and relationships in the House of Delegates was important. Because co-sponsoring another delegation’s resolution is tantamount to adding the MSS as authors of that other resolution and adds additional work to the already-high workload of the MSS Caucus, the RTF felt that co-sponsoring another delegation’s resolutions required a high degree of consensus in the MSS Caucus, and thus recommended requiring a 2/3rds vote of the MSS Caucus. By contrast, there are limited drawbacks to other delegations co-sponsoring MSS-authored resolutions, and the RTF therefore recommended allowing the Section Delegates to add other interested delegations as co-sponsors of MSS resolutions unilaterally so as to ease administrative burden.

<u>Reaffirmation</u>

As provided for in 630.037MSS, “Reaffirmation Calendar”, the MSS uses a Reaffirmation Consent Calendar in a similar fashion to the House of Delegates to reaffirm existing AMA-MSS policy, with the notable exception that extraction from the MSS Reaffirmation Consent Calendar requires a 1/3rds vote of the Assembly as per the current MSS IOPs (MSS IOPs, Section 10.8.6), whereas extraction from the HOD Reaffirmation Consent Calendar does not require a vote. 630.037MSS also provides for a mechanism whereby resolutions that are deemed “identical or nearly identical to existing AMA policy” will provide for formal statements of support for that existing AMA policy in the MSS Digest of Policy Actions via the Reaffirmation Consent Calendar (see “Statements of formal support” subsection below for a more thorough discussion). This indirect mechanism of statements of formal support is a necessary one in order to allow for motions to reaffirm external AMA policy to be a coherent motion, as the MSS has no power or authority to reaffirm existing AMA policy, which is the sole prerogative of the House of Delegates. Even with this mechanism in place, the language used for this motion in Reference Committee Reports and on the floor of the MSS Assembly, which generally takes the form of “That AMA Policy X be reaffirmed in lieu of Resolution Y”, is in a strict sense incorrect and meaningless, because the MSS Assembly *cannot* reaffirm AMA policy. The motion demands an action from the MSS that the MSS is incapable of actually performing.

The RTF concluded that the incoherent nature of an external reaffirmation (here meaning a motion to reaffirm AMA policy in lieu of an MSS item of business) makes its continued use unjustifiable. To that end, the RTF recommends rescission of 630.037MSS, which is the only

language in the Digest of Policy Actions or IOPs that establishes a mechanism for external reaffirmation. In the absence of 630.037MSS, external reaffirmation would no longer be in order, and thus would not be an allowable motion on the floor of the MSS Assembly. The RTF considered how the Reference Committee and Assembly members should approach items of business whose asks are already covered by existing AMA policy and which would therefore normally be reaffirmed according to the mechanism provided for in 630.037MSS. The RTF noted that not adopting a resolution that is covered by existing AMA policy or amending the resolution to make the language internal MSS policy are existing alternatives to external reaffirmation. The RTF therefore recommends using these motions where appropriate in lieu of reaffirmations of external AMA policy.

The RTF also discussed whether continuing to permit reaffirmation of *internal* MSS policy was a wise course of action, and ultimately concluded that it was. Discussion focused around what a reaffirmation functionally does. Normally, as provided for in 630.044MSS, "Sunset Mechanism for AMA-MSS Policy", MSS policies are reviewed every five years and are either retained or rescinded ("sunset") through the annual Sunset Report authored by the MSS Governing Council. Reaffirmations of internal MSS policy reset this clock, such that policies are renewed for an additional five years from being potentially rescinded through the sunset mechanism. Thus, reaffirming internal policy practically exempts it from being sunset for five years. The RTF discussed whether reaffirming internal policy via direct Assembly action or via the Sunset Report, which receives input from MSS standing committees and the MSS Governing Council and is ultimately passed by the MSS Assembly, was a better course of action. Ultimately, the RTF decided that continuing to allow the Assembly to reaffirm existing internal MSS policy maximized the flexibility of the Assembly, and thus recommended that reaffirmations of internal MSS policy remain allowable motions.

<u>The role of HCC in the MSS policy process</u>

As provided for in 630.075MSS, the House Coordinating Committee is responsible for setting the Reaffirmation Consent Calendar (for additional information, see "Background" section, subsection "Reaffirmation Consent Calendar"). This process, which requires that the entirety of AMA and MSS policy be reviewed for each idea posted on the Open Forum and each rough draft and final resolution submitted, has created an exceptionally large and unsustainable amount of work for HCC that detracts from its ability to perform any other useful function. The rescission of 630.037MSS and consequent impermissibility of external reaffirmation partially resolves this dilemma. The RTF noted, however, that the original impetus for giving HCC the responsibility to set the Reaffirmation Consent Calendar, as opposed to the Reference Committee, was to provide a mechanism for AMA staff to not have to review resolutions that were likely to be recommended for reaffirmation, so as to reduce staff workload. Since the Reference Committee provides recommendations long after AMA staff has reviewed resolutions, another entity needed to set the Reaffirmation Consent Calendar; the entity selected was HCC.

Importantly, that intended function has not been fulfilled, as AMA staff still reviews final resolutions and provides feedback prior to HCC setting the Reaffirmation Consent Calendar. Therefore, because the original purpose of providing HCC sole responsibility to set the Reaffirmation Consent Calendar instead of the Reference Committee is not being fulfilled, the RTF recommends returning the final prerogative to set the Reaffirmation Consent Calendar to the Reference Committee, who, by virtue of seeing all commentary on a resolution via the Virtual Reference Committee, has much broader access to the opinions of stakeholders from across the MSS and external partners than HCC does. This change is accomplished by the language in the first resolve clause of the RTF's recommendations specifying that "reaffirmation in lieu of" is an available recommendation in the Reference Committee Report, and via rescission of 630.075MSS wherein the responsibility of setting the Reaffirmation Consent Calendar is given to HCC.

Liberating HCC from the titanic task of setting the Reaffirmation Consent Calendar raises the question of what HCC's future role in the MSS policy process will be. This is a question that the RTF has deliberately chosen not to answer. Some possibilities raised in the RTF's discussions included: being incorporated into the resolution writing and review process run by the Section Delegates; continuing to provide resolution authors feedback on novelty in a non-binding manner; acting as an opportunity for individuals interested in running for the MSS Caucus to familiarize themselves with the resolution review process and the workings of the House of Delegates; and acting as a source of living, institutional memory for MSS actions in the House of Delegates. The RTF elected to leave this question up to future Governing Councils and HCC Co-Chairs who would be directly responsible for implementing any changes. The possibilities are, needless to say, exciting.

Finally, questions had been raised about HCC's role as a standing committee and whether it should continue to be under the Vice Chair, who is responsible for all standing committees (MSS IOPs, Section 4.4.2.3), or the Section Delegates, who interact with HCC far more frequently day-to-day. The RTF noted that modern MSS Governing Councils have understood HCC to technically be under the Vice Chair's purview but practically under the authority of the Section Delegates on matters pertaining to the resolution review process or the House of Delegates, and that this informal arrangement has, to date, functioned well. Furthermore, concern was raised that to officially place HCC under the Section Delegates would require either an amendment to the MSS IOPs or the recognition that HCC was not officially a standing committee, the former of which was considered an extreme measure and the latter of which would require removing HCC from the standing committee application process, which might hurt HCC membership. Therefore, the RTF elected to maintain the status quo where HCC is a standing committee under the purview of the Vice Chair that is nevertheless understood to predominantly work with the Section Delegates.

Statements of formal support

As noted above, 630.037MSS establishes a mechanism whereby external reaffirmations result in statements of formal support for the AMA policies that were "reaffirmed" (with the caveat that, of course, those AMA policies were never actually reaffirmed by MSS Assembly action; see subsection "Reaffirmation" for a more thorough discussion). Thus, every reaffirmation of AMA policy should result in a statement of formal support. The RTF noted that the statements of formal support have not been updated since 2019, despite the requirements laid out in 630.037MSS. Furthermore, the RTF noted that reaffirmations of AMA policy are often done because a relatively small part of what can be a significantly larger AMA policy covers an MSS resolution. Practically, because the formal support mechanism is not widely known across the MSS, large AMA policies with language that the MSS Assembly might not support have been quietly imported into the MSS Digest of Policy Actions without meaningful oversight (albeit not since 2019). Because of this potentially confusing and dangerous consequence, and because the RTF elected to recommend removal of external reaffirmation as an available motion in the MSS Assembly, the RTF recommends that removing all existing statements of support is the safest course of action. The RTF also noted that removing the statements of formal support, which currently occupies 82 pages of the MSS Digest of Policy Actions, would substantially simplify and shorten the MSS policy compendium.

Policies recommended for rescission

What follows is a table which details each policy recommended for rescission or amendment and the associated rationale.

Policy	Decision and rationale
630.008MSS Referencing Data in Resolutions It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information.	**Rescind** Whether a given resolution has sufficient evidentiary support is the prerogative of the MSS Assembly. Furthermore, MSS culture adequately enforces this requirement.
630.016MSS MSS Reference Committee Information AMA-MSS and the Medical Student Section will release to members of the MSS assembly a copy of the AMA-MSS Reference Committee Report online prior to and for the duration of the AMA-MSS meeting.	**Rescind** This is unnecessary and redundant given the ubiquitously electronic nature of AMA and MSS business in the modern era. Additionally, the MSS IOPs already requires that all resolutions be sent to all AMA-MSS Delegates and Alternate Delegates via the meeting Agenda prior to the meeting (Section 10.8.2.1), which *de facto* requires the release of the Reference Committee Report in a similar manner (as the Agenda, Handbook, and Reference Committee Report are always released together).
630.037MSS Reaffirmation Calendar AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.	**Rescind** This policy establishes a pathway for external reaffirmation via providing for “statements of formal support” of reaffirmed AMA policy. By rescinding this policy, external reaffirmation is removed as an available motion at the MSS Assembly.
630.051MSS AMA-MSS Digest of Actions It is the policy of the AMA-MSS that the AMA-MSS Internal Operating Procedures and Digest of Actions be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly.	**Rescind** Incorporated into the RTF recommendations.
630.055MSS Implementation of MSS Policy AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current,	**Rescind** This policy is prescriptive, and requires the Governing Council to report at *each meeting* of the progress of all resolutions passed *up to five*

especially focusing on action called for by external policies.	*years previously*, which would require an extensive analysis of information that can be exceptionally difficult to find. Furthermore, this directive has not been followed for several years by successive Governing Councils. To avoid keeping directives in MSS policy that are routinely violated, this policy should be rescinded.
630.074MSS Review of AMA-MSS Statements of Support of HOD Policies (1) The formally supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the "AMA-MSS Statements of Support for HOD Policies" section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.	**Rescind** The RTF is recommending elimination of the formal support mechanism for external reaffirmation, and the rescission of all statements of formal support. Therefore, this directive to regularly study the statements of formal support should be rescinded.
630.075MSS Pilot Implementation of the 2018 Resolution Task Force Recommendations MSS will: 1) Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and b) Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made; 2) Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-	**Rescind** This policy, born of the recommendations from the 2018 Resolution Task Force, recommends various prescriptive directives to improve the MSS policy process. While those specific directives may have been necessary at the time, the MSS policy process has continued to grow and evolve since that date, and has largely moved beyond the recommendations in this policy. By rescinding this policy and replacing it with more general language that establishes the contours of the MSS policy process, and leaves the specifics of implementation up to individual Section Delegates, the MSS will facilitate a greater range of flexibility and innovation while retaining the capacity of future Section Delegates to continue following the precedent of those recommendations that have proven their worth over time. Furthermore, this policy foists the responsibility for setting the Reaffirmation Consent Calendar upon HCC. To pass that responsibility to the Reference Committee, this policy must be rescinded. Finally, in order to allow the order of business to be set without the use of resolution scores, this policy, which reaffirms that exact practice, must be rescinded.

resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee; 3) Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring all external resolution authors to contact the relevant specialty society prior to submission; 4) Improve transparency of resolution feedback among all actors throughout the resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers to send feedback summary emails to the primary author's Region Chair and Region Delegation Chari in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;	

5) Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC; 6) Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category; 7) Reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores; 8) Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; and 9) Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact.	

An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year.	
645.023MSS Medical Student Section Policy Making Procedures 1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; 2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates; 3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD's "Implementation of Resolutions and Report Recommendations" documents, and that these updates be archived as an historical record of GC actions; 4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; 5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; 6) AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist; 7) When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted.	**Rescind** This policy contains highly prescriptive asks that are either not generally done or that are better left to the discretion of the Section Delegates and Governing Council. Additionally, this policy reaffirms the MSS's use of a Reaffirmation Consent Calendar, which should be rescinded in order to streamline the process by which the MSS Assembly interacts with the Reference Committee Report. Finally, the spirit of point 7, which provides the Section Delegates the power to re-transmit resolutions that were not adopted to the House of Delegates when the respective MSS policy is due to be sunset, has been broadened and elsewhere incorporated into the RTF's recommendations.
645.031MSS Policy-making Procedures	**Amend (see "Recommendations" for language)**

1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. 2) A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. 3) That Reference Committees be encouraged to recommend GC Action Items in future report reasoning. 4) All authored resolutions are submitted to the region of the resolution's primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution's author to offer feedback and suggestions prior to the MSS final resolution deadline. 5) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author's school is not located, with each resolution's average ranking subsequently being released to the author. 6) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be	The RTF felt that this additional policy on MSS policy-making procedures was redundant, outdated, and overly prescriptive, and was prepared to recommend this policy for wholesale rescission. However, the RTF noted that point 2, which creates general guidelines for increasing the transparency of MSS Action Items (referred to as "GC Action Items" in the policy), provided an important contribution to the MSS policy compendium that was unique and found in no other policies. Therefore, the RTF recommended striking all the language not pertaining to MSS Action Items and amending the title to reflect the change in focus of the policy. The RTF also noted, however, that point 6, which requires the MSS to release formatting guidelines and a resolution template to assist with formatting, is still relevant and contains important protections for authors. Therefore, language to require the MSS to release a resolution template was incorporated in resolve 1 of the RTF's recommendations. Resolve 1 of the RTF's recommendations also permits the issuance of formatting requirements, which *de facto* implies that they be made public as point 6 currently requires.

accepted until properly formatted within the established deadlines.	
645.032MSS Continued Support for the Virtual Reference Committee AMA-MSS supports the continued implementation and utilization of the Virtual Reference Committee, including the use of online testimony to develop a Reference Committee report prior to each AMA and AMA-MSS national meeting.	**Rescind** Redundant; already in MSS IOPs (Section 10.8.2.1).
645.034MSS Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates AMA-MSS will study the outcomes of MSS resolutions in the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures of the degree to which MSS goals were met regardless of outcome. The AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate, consider using the results of the study to continue to improve and update the resolution writing process and report back to the MSS Assembly at intervals deemed appropriate by the AMA-MSS Governing Council.	**Rescind** This study has been subsumed by the original 2018 Resolution Task Force and subsequent GC reports to implement the Task Force's recommendations in 2018 and 2019. Further, there is no evidence it has meaningfully been acted upon since its passage. It is therefore redundant, and should be rescinded.

Study of institutional memory in the MSS

During the RTF Town Hall, multiple MSS members raised questions about institutional memory in the MSS, specifically regarding how our Section can better preserve the ultimate fate and advocacy impact of resolutions and reports adopted by the MSS Assembly. These members noted that multiple policies recommended for rescission by the RTF, including 630.055MSS, 645.023MSS, and 645.034MSS, ask for studies of the results and impact of MSS resolutions, indicating there is appetite in the Assembly for a better architecture for institutional memory. The RTF concurred with this assessment. Though specific recommendations on how to improve MSS institutional memory are outside the scope of this report, the RTF felt that commissioning a study to take a detailed look at this issue was warranted given the volume of policies related to institutional memory that are recommended for rescission in this report and given the vocal support for a study on the RTF Town Hall.

CONCLUSION

The 2023 Resolution Task Force has taken a sweeping view of MSS policy pertaining to the resolution writing and review process and recommended detailed edits to consolidate policy, reduce redundancies, eliminate overly prescriptive requirements, and create new opportunities for future innovation and improvement. Furthermore, the recommendations of the RTF promise to reduce the workload of overburdened stakeholders in HCC and the MSS Caucus, by

removing the burden of the Reaffirmation Consent Calendar and final resolution scoring, respectively. Finally, by engaging experienced members from across the MSS and opening its deliberations to the MSS writ large, the RTF has crafted these recommendations in as democratic and considered a manner as possible. Your Resolution Task Force and Governing Council are grateful for the opportunity to present these recommendations to the MSS Assembly, and look forward to the MSS continuing its storied legacy of continually improving the quality of the resolutions adopted by its Assembly.

RECOMMENDATIONS

Your AMA-MSS Governing Council and Resolution Task Force recommend that the following recommendations be adopted and the remainder of the report be filed:

RESOLVED, That our AMA-MSS adopt the following as our MSS Policy Process:

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.

2. The review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS committees; other MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.

3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.

4. No resolutions submitted by the correct deadline in the correct format may be rejected for submission for consideration by the MSS Assembly based on their content.

5. Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. The timeline and procedure for extracting items from the Reference Committee Report will be set by the MSS Section Delegates.

6. The AMA-MSS Internal Operating Procedures and Digest of Actions will be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly.

7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.

; and be it further

RESOLVED, That our AMA-MSS adopt the following as Additional MSS Caucus Operations:

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.
2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
   a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
   b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

; and be it further

RESOLVED, That our AMA-MSS amend 645.031MSS, "Policy-making Procedures," by addition and deletion as follows:

645.031MSS MSS Action Items ~~Policy-making Procedures~~

~~1. A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions.~~

2. A list of all ~~GC~~MSS Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss ~~GC~~MSS Action Item implementation status with interested students. ~~Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.~~

~~3. That Reference Committees be encouraged to recommend GC Action Items in future report reasoning.~~

~~4. All authored resolutions are submitted to the region of the resolution's primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution's author to offer feedback and suggestions prior to the MSS final resolution deadline.~~

~~5. All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author's school is not located, with each resolution's average ranking subsequently being released to the author.~~

~~6. Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not~~

~~meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines.~~

; and be it further

RESOLVED, That our AMA-MSS reaffirm 630.007MSS and 630.025MSS; and be it further

RESOLVED, That our AMA-MSS rescind 630.008MSS, 630.016MSS, 630.037MSS, 630.051MSS, 630.055MSS, 630.074MSS, 630.075MSS, 645.023MSS, 645.032MSS, and 645.034MSS; and be it further

RESOLVED, That our AMA-MSS rescind all statements of formal support for AMA policies listed in the section “AMA-MSS Statements of Support for HOD Policies” of the MSS Digest of Policy Actions; and be it further

RESOLVED, That our AMA-MSS will investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the MSS.

RELEVANT AMA AND AMA-MSS POLICY

AMA Bylaw 2.11.3.1.3 Late Resolutions
Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

AMA Bylaw 2.11.3.1.4 Emergency Resolutions
Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

MSS Internal Operating Procedure 4.4.2 Vice Chair
The Vice Chair shall:
4.4.2.1. Preside at meetings of the Governing Council in the absence of the Chair or at the request of the Chair.
4.4.2.2. Assist the Chair in the performance of his or her duties.
4.4.2.3. Have the primary responsibility of coordinating the internal operations of the MSS, including but not limited to the MSS standing and ad-hoc committees.

MSS Internal Operating Procedure 4.4.3 AMA Delegate and Alternate Delegate
The AMA Delegate and Alternate Delegate shall:
4.4.3.1. Represent the MSS in the AMA House of Delegates.
4.4.3.2. Serve as Chair and Vice Chair, respectively, of the MSS Caucus.
4.4.3.3. Forward resolutions from the MSS in the HOD and provide a summary of pertinent actions for the MSS on resolutions sent to the HOD.
4.4.3.4. Administer the MSS resolution review process.

MSS Internal Operating Procedure 10.8.2.1
Virtual Reference Committee. All reports and resolutions that meet submission criteria will be made available on the Virtual Reference Committee. Any AMA MSS member can comment on MSS business. Comments can be made on behalf of an individual, a medical student section at a medical school, a state medical student section, an organization represented in the Assembly, and/or an AMA MSS Region, provided sufficient authority exists for such commentary. All comments will be made available to the Reference Committee(s). The resolutions will be sent to all duly selected and certified MSS Delegates and Alternate MSS Delegates prior to the Assembly Meeting via the meeting Agenda and are debatable on the floor of the MSS Assembly.

MSS Internal Operating Procedure 10.8.6
Extraction of a resolution recommended for reaffirmation by the Reference Committee shall require a one-third vote of delegates present and voting.

630.007MSS MSS Resolutions
It is the policy of the AMA-MSS that MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, once submitted to the Medical Student Section may not, with the exception of retyping, be altered by staff or an MSS council or committee prior to the MSS Assembly Meeting without the consent of the author.

630.008MSS Referencing Data in Resolutions
It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information.
(MSS Res 28, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

630.016MSS MSS Reference Committee Information
AMA-MSS and the Medical Student Section will release to members of the MSS assembly a copy of the AMA-MSS Reference Committee Report online prior to and for the duration of the AMA-MSS meeting.
(MSS Amended Res 7, A-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I- 10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

630.019MSS MSS Master List of Dates
AMA-MSS will compile a yearly "Master List of Dates," which will identify important deadlines for MSS and AMA activities and programs which will be made available to all members.
(MSS Res 22, I-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

630.025MSS Changes in MSS Resolutions Forwarded to the AMA House of Delegates
It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House of Delegates (when they agree) may make grammatical or syntax changes in MSS

resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution. (MSS Res 43, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

630.037MSS Reaffirmation Calendar

AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.
(MSS Amended Res 17, A-93) (MSS Rep C, I-93) (MSS Amended Rep C, I-97) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

630.051MSS AMA-MSS Digest of Actions

It is the policy of the AMA-MSS that the AMA-MSS Internal Operating Procedures and Digest of Actions be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly.
(MSS Sub Res 21, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

630.055MSS Implementation of MSS Policy

AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current, especially focusing on action called for by external policies.
(MSS Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

630.074MSS Review of AMA-MSS Statements of Support of HOD Policies

(1) The formally supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.
(MSS GC Report B, A-17)

630.075MSS Pilot Implementation of the 2018 Resolution Task Force Recommendations

MSS will:

1. Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and b) Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made;
2. Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the

Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee;

3. Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring all external resolution authors to contact the relevant specialty society prior to submission;

4. Improve transparency of resolution feedback among all actors throughout the resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers to send feedback summary emails to the primary author's Region Chair and Region Delegation Chari in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;

5. Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC;

6. Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category;

7. Reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores;

8. Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; and

9. Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates

and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year.
(Amended GC Rep A, A-18)

645.023MSS Medical Student Section Policy Making Procedures

1. As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue;
2. When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates;
3. The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD's "Implementation of Resolutions and Report Recommendations" documents, and that these updates be archived as an historical record of GC actions;
4. AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar;
5. The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar;
6. AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist;
7. When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted.

(MSS Rep A, A-08) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

645.031MSS Policy-making Procedures

1. A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions.
2. A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.
3. That Reference Committees be encouraged to recommend GC Action Items in future report reasoning.
4. All authored resolutions are submitted to the region of the resolution's primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution's author to offer feedback and suggestions prior to the MSS final resolution deadline.

15. All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author's school is not located, with each resolution's average ranking subsequently being released to the author.
56. Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines.

(Amended GC Rep A, A-13) (Amended and Reaffirmed: MSS GC Rep A, I-19) (Amended: Res. 027, A-21)

645.032MSS Continued Support for the Virtual Reference Committee

AMA-MSS supports the continued implementation and utilization of the Virtual Reference Committee, including the use of online testimony to develop a Reference Committee report prior to each AMA and AMA-MSS national meeting.

(MSS Res 9, I-13) (Reaffirmed: MSS GC Rep A, I-19)

645.034MSS Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates

AMA-MSS will study the outcomes of MSS resolutions in the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures of the degree to which MSS goals were met regardless of outcome. The AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate, consider using the results of the study to continue to improve and update the resolution writing process and report back to the MSS Assembly at intervals deemed appropriate by the AMA-MSS Governing Council.

(MSS Res 02, I-17)

Appendix A: 2023 Resolution Task Force Charter

2023 MSS Resolution Process Task Force

Background

At the 2017 Interim Meeting of the AMA Medical Student Section (MSS), the Assembly received an unprecedented number of resolutions for discussion and evaluation. This prompted the MSS Governing Council (GC) to form a Resolution Task Force to suggest improvements to the MSS policy process to address the number of resolutions, their quality, and improve the efficiency of the Assembly. The Task Force made recommendations, presented at the A-18 Annual Meeting, that ultimately resulted in the adoption of Policy 630.075MSS, "Pilot Implementation of the 2018 Resolution Task Force Recommendations", which have guided the MSS Section Delegates in implementing the policy process ever since.

The 2021-2022 MSS GC prepared GC Report B ("the report") for A-22 to review the implementation of the 2018 Resolution Task Force's recommendations and suggest additional improvements. Commentary on the Virtual Reference Committee (VRC) raised questions about various aspects of the recommendations, including the role of virtual extractions, how to incorporate equity in the resolution writing process, the role of the House Coordinating Committee (HCC) in setting the reaffirmation calendar, and whether sufficient perspectives had been solicited from stakeholders in the MSS when authoring the report. The Reference Committee recommended referral of the report, and the Assembly adopted this recommendation.

Task Force Charter

In order to effectively solicit sufficient input from a variety of voices within the Section, the 2022-2023 MSS GC voted to reconstitute the Resolution Task Force, to review the recommendations from A-22 GC Report B and associated VRC commentary. Additionally, the MSS GC is assigning this Resolution Task Force with reviewing the formal support mechanism for external reaffirmations, whether this mechanism is the optimal method to handle external reaffirmations in the MSS Policy Digest, and any other methods to optimize the MSS policy process. The MSS GC will consider the Task Force's recommendations and will jointly produce a report with the Task Force for the 2023 Annual Meeting detailing those recommendations, the associated rationale, and any changes to the MSS Policy Digest or MSS Internal Operating Procedures that should be made.

The charge to the 2023 MSS Resolution Process Task Force is to:

1. Review the recommendations from the A-22 GC Report B, including the rationale provided in the report, associated VRC commentary, and any other relevant or pertinent information; and
2. Clarify the role of HCC in the MSS policy process, specifically:
    a. Whether the reaffirmation calendar ought to continue to be an HCC responsibility; and
    b. Whether HCC should be under the purview of the Vice Chair or the Section Delegates; and
3. Review the mechanism whereby external reaffirmations result in "statements of formal support" as detailed in 630.037MSS, including:
    a. Whether this process accurately reflects the will of the Section; and

b. How this process impacts the MSS Policy Digest, including its length and readability; and
c. The relative strengths and weaknesses of other mechanisms to handle external reaffirmations in the MSS Policy Digest; and

4. Report formal recommendations back to the MSS Governing Council prior to the opening of the Virtual Reference Committee.

Task Force Composition

The MSS Resolution Process Task Force shall have the following composition:

Co-Chairs:

MSS Section Delegate *(non-voting)*
MSS Section Alternate Delegate *(non-voting)*

Members:

The Task Force shall be comprised of 9 voting members selected by the Task Force Co-Chairs and three nonvoting members, including the Task Force Co-Chairs. Further, the MSS Chair will serve as the Task Force Secretary. Two voting members will be selected from HCC by the HCC Co-Chairs, while the remaining 7 voting members will be at-large members from across the Section selected by the Co-Chairs. When selecting members, the Co-Chairs should consider applicant familiarity with the MSS resolution writing process, the MSS Assembly, and the AMA House of Delegates, and should prioritize applicants who have served on MSS Caucus and/or HCC. The Co-Chairs are encouraged to select applicants from as broad an array of MSS Regions as possible to ensure equitable representation.

Meetings of the Task Force will be scheduled and facilitated by the non-voting Co-Chairs. The MSS Speakers will also be invited as permanent guests to answer any questions regarding the Assembly process but will not otherwise be participating members of the Task Force.

Task Force Meetings

The Task Force is expected to meet four times via conference call to facilitate discussion. The estimated duration of each meeting is two hours. Additionally, the Task Force will hold two town halls that will be open to the public to solicit feedback from the Section. The estimated duration of each town hall will be one and a half hours. The final recommendations will require the approval of a majority of voting members to be forwarded to the MSS Governing Council, which will also be required to approve the recommendations independently of the Task Force. If a voting member will not be present to approve the final recommendations, the Co-Chairs may designate one of the nonvoting members to vote in their place.

The Task Force Secretary will, in consultation with the Co-Chairs, prepare minutes of every Task Force meeting, which will be published for MSS Assembly viewing after approval by the Task Force. To facilitate open discussion, minutes will be de-identified before release. Task Force meetings will be closed, but the Task Force shall have the power to invite guests and observers to one or more of its meetings at its discretion to provide required information.

REPORT OF THE MEDICAL STUDENT SECTION

MSS Delegate Report A
(A-23)

Introduced by:	Ryan Englander, Section Delegate; Brittany Ikwuagwu, Alternate Section Delegate
Subject:	Delegate Report A: Status of Pending MSS-Authored Resolutions to the House of Delegates
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

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INTRODUCTION

The AMA Medical Student Section serves to provide "meaningful input into the decision and policy-making process of the AMA," (IOP 2.1) "promote membership and activity within organized medicine on the local, state, and national levels,"(IOP 2.7) and "work cooperatively with other student groups and AMA Sections to meet [stated] objectives" (IOP 2.8) for medical student members of the AMA. One of the ways in which the MSS achieves this purpose is by participating in the AMA House of Delegates (HOD) through the submission of MSS-authored resolutions. To be considered by the HOD, MSS-authored resolutions must first be submitted to the MSS Assembly by MSS member(s) and adopted at a national meeting of the MSS Assembly.

In accordance with IOP 10.4.5, the purpose of the MSS Assembly is "to adopt resolutions for MSS Policy and for submission to the House of Delegates of the AMA". If a resolution secures a simple majority vote for adoption by the Assembly, it can be incorporated into the MSS Digest of Policy Actions ("internal resolution") and/or forwarded for consideration by the AMA HOD as an MSS-authored resolution ("external resolution"). Notably, IOP 10.8.8 decrees that external resolutions "shall be submitted to the AMA House of Delegates at the next appropriate meeting". Resolutions to be transmitted to the HOD shall be referred to as "transmittals" for the duration of this report.

AMA SPECIAL MEETINGS AND THE MSS TRANSMITTAL SELECTION PROCESS

Last Special Meeting, including limited policy considerations: November 2021

Following the precedent of actions taken at the previous two special meetings and recognizing that the November 2021 meeting would have special procedures regarding prioritization, the current (2021–2022) Section Delegates anticipated a need to decide which resolutions to transmit at the 2021 November Meeting and began working with the Caucus on this process on August 10, 2021. The Speakers named the November 2021 Meeting a Special Meeting on August 27, 2021. Following this announcement, they also informed the House that there would be a prioritization process involving a resolutions committee, similar to the ones which had been used at the prior two meetings. Given this, your section delegates found merit in developing a transmittal process for the upcoming meeting that was based on previous transmittal plans and

the wants of our MSS Caucus. On August 26, 2021, your previous section delegates held a town hall regarding the section's transmittal process where we heard the following concerns and desires for a transmittal process:

1. Regional Delegates asked for increased guidance from Section Delegates. Specifically, it was requested that the Section Delegates offer more direct recommendations and guidance regarding how to handle individual transmittals.

2. There is an inherent amount of subjectivity that can be introduced through a scoring system when not everyone scores every resolution. This can lead to a less valid measure of what is actually a top priority item for our section.

3. The volume of work associated with previous transmittal processes has been significant and often cumbersome at times for our regional delegates.

4. The criteria for prioritizing transmittals must consider urgency, both in terms of timeliness (or what is going to happen if we do/don't have this policy in place in the next 6-12 months) and in terms of MSS priorities (or what are the things we are jumping to have passed, today if possible), and considerations of things specific to medical students. Additionally, there were requests to better account for the amount of time that a resolution had been in the transmittal queue.

5. Involvement from our caucus and section members must remain a priority for any transmittal process but should focus on gathering valuable input about transmittals. Specific suggestions on how to accomplish this including allowing for individuals to provide comments on items that related to each of the considerations listed in point 4.

6. Equity must remain a focus of any transmittal process and should be priority in not only the theme of the resolutions we decide to transmit, but also within the process itself. Specifically, requests were made to solicit input from equity-focused NMSOs and similar groups within our Section, and that this input be heavily weighed.

7. The resolutions committee and its processes have been concerning for our Section members and caucus, which raised various questions about the number of items we should transmit. There were suggestions that we should transmit our entire queue, while others felt the need to only transmit a select number of items in order to maintain political capital within the House. Ultimately, the majority of voices heard felt that we should increase the number of transmittals that we send to the House as compared to previous meetings.

With these concerns in mind, your 2021-2022 Section Delegates developed a transmittal plan with the following stages (the full details are available here):

1. Step 1: Spreadsheets for comments on each resolution were made available to Caucus members, resolution authors, and the Section. Comments were solicited in terms of a) the urgency and timeliness of the issue, b) particular relevance to medical students, and c) MSS priority.

2. Step 2: The Section Delegates assigned different overarching "themes" (for example, gender equity, public assistance, disability rights, etc) to each resolution. A list of 28 themes was extracted from the 105 transmittals in this way. Caucus members were then

asked to vote on the order in which these themes should be considered priority.

3. Step 3: Once the themes were ranked, the Section Delegates ordered the transmittals by their highest ranking themes. The Delegates then rearranged this ordering using the comments on the comment spreadsheets from Step 1 and released this preliminary transmittal ranking to the Caucus. The comment spreadsheets remained open, and comments on further rearrangement were encouraged.

4. Step 4: The Caucus held a meeting in which to decide upon the final transmittal list. Any member was able to extract an item and suggest its movement up or down in the transmittal list. At the end of this meeting, 50 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2021–2022 executed this transmittal plan according to the November 2021 Transmittal Calendar (Appendix 1). On September 30, 2021, your 2021-2022 section delegates submitted 50 resolutions and priority statements for consideration to the House. This represented the largest volume of resolutions that our section had transmitted to the House at that time.

First in Person Meeting Since the COVID-19 Pandemic: 2022 Annual Meeting

The 2022 Annual Meeting was an in-person regular meeting that took place in Chicago from June 10-15, 2022. This meeting was announced as a regular meeting that will be governed by any AMA bylaws and precedent pertaining to these meetings. Therefore, it was determined that the prior prioritization process involving a resolutions committee, similar to the ones which had been used at the prior three meetings, would not be utilized at this meeting.

Regardless, the Speakers of the AMA House of Delegates did encourage all constituent societies and sections to be mindful of the volume of business that would be transmitted to the House, especially considering the large backlog that existed due to the virtual nature of the prior three meetings. Given these considerations, your 2021-2022 section delegates found merit in continuing to utilize a similar transmittal process in order to decide which resolutions should be transmitted to the House.

On March 8, 2022, your 2021-2022 Section Delegates held a caucus meeting regarding the Section's transmittal process, in which they described previous processes and solicited feedback, comments, and concerns. Caucus members and liaisons and other leadership present expressed the importance of a) balancing the workload for current delegates; b) balancing the number of controversial and noncontroversial resolutions sent for this meeting, and responsibility to the burden future caucuses will have to send; c) fairness to the many transmittals remaining in our queue and ensuring each one is heard and excellently defended in a timely manner; and d) continuing to have greater guidance from the Section Delegates while maintaining crucial spaces for delegate input and feedback into processes and decision
With this in mind, your 2021-2022 Section Delegates developed a transmittal plan with the following stages (the full details are available here):

1. Step 1: Spreadsheets for comments on each resolution were made available to Caucus members, resolution authors, and the Section. Comments were solicited in terms of a) urgency, b) timeliness, c) medical student specificity, d) support from other groups, e) degree of controversiality, f) whether transmittals could be combined with others, g) whether the ask of any transmittal's aims has already been accomplished by other means, and h) any other comments members believed may be helpful.

2. Step 2: The Section Delegates assigned different “themes” (for example, gender equity, public assistance, disability rights, etc) to each resolution, with each resolution having more than one theme. The 28 themes extracted from transmittals from November 2021 were found to completely cover the 113 transmittals in the queue at this time. Caucus members were again asked to vote on the order in which these themes should be considered priority.

3. Step 3: The SDs then arranged the resolutions by highest-ranking themes and, along with considering comments from the comment sheet and the amount of time we’ve held each transmittal, the SDs chose ~30-35 transmittals for a Preliminary Transmittal Calendar. This list was then sent to the caucus and released to the section. The comment spreadsheets remained open, and comments on further rearrangement were encouraged.

4. Step 4: The Caucus held a meeting in which to decide upon the final transmittal list. Any member was able to extract an item and suggest its addition or removal from the final transmittal list. At the end of this meeting, 37 resolutions were ordered for preparation to be transmitted to the House of Delegates.
5. Step 5: The remaining 13 transmittals were selected via a randomized lottery that was conducted by your section delegates, who still took into account the comments/ controversiality/etc. of any resolution selected by lottery. These transmittals were then added to the final transmittal list and all 50 resolutions were approved for transmittal to the House via a majority vote of the MSS Caucus.

Your 2021–2022 Section Delegates executed this transmittal plan according to the Annual 2022
Transmittal Calendar (Appendix 1). On April 8, 2022, your 2021-2022 section delegates submitted 23 previously submitted resolutions for consideration to the House. Your section delegates submitted the remaining 27 “on-time” resolutions to the House before the deadline of May 11, 2022. This represents the largest volume of resolutions that our section transmitted to the House at a regular, in-person meeting.

Last Meeting: Interim 2022
The Interim 2022 Meeting is scheduled as an in person meeting to take place in Honolulu, HI from November 10-15, 2022. In preparation for this meeting, your Section Delegates went through the pending transmittal list and discussed the best way to move forward in an effort to clear our section’s backlog. For this effort, on August 15, 2022 the first Caucus meeting was held to discuss the best way forward in choosing which transmittals should be sent to the House of Delegates for the I-22 Meeting. Following this initial Caucus meeting, the following was decided on how the process should proceed:

1. First, it was confirmed that we should continue with the theme prioritization process that was utilized at the A-22 meeting. Your Section Delegates assigned one of 28 themes to each resolution, after which Caucus members were asked to vote on the order in which these themes should be considered priority.

2. After consideration of the A-22 transmittal process, it was decided that your Section Delegations come up with an additional way to prioritize transmittal by considering the timeliness of each resolution. After deliberation, your Section

Delegates proposed to score each resolution by three characteristics, each on a 1|2|3 point scale. The sum of these scores were added up and used to rank resolutions (minimum score of 3, maximum of 9). Those characteristics were as follows:

Impact (to be scored by the Caucus):

- 3 - High impact
  - Substantial change to policy OR fills a massive gap
  - Impacts a large group or has a profound impact on a smaller group
- 2 - Moderate impact
  - Changes policy or fills a gap that impacts a core issue
  - Has a small impact on a large group or impacts a smaller group
- 1 - Low impact
  - Unlikely to substantially change AMA advocacy OR effect will be limited

Urgency (to be scored by Caucus):

- 3 - High urgency
  - Failure of AMA to act NOW may lead to irreparable harm to the ISSUE
    - Note that this does not consider the impact that acting on this issue may have, but only whether failure to act now will preclude future action!
- 2 - Moderate urgency
  - AMA engagement would materially assist the ISSUE in the short term but would not cause irreparable harm if there was no action
- 1 - Low urgency
  - AMA action can be delayed indefinitely without causing harm to advocacy on the issue

Length of time in queue:

- 3 - Passed in I-20 or before
- 2 - Passed in A-21 or I-21
- 1 - Passed in A-22

For the criteria listed as reviewed by the Caucus, we randomly assigned 10 transmittals per person to score for urgency and impact. Note that these were *just based on the resolved clauses*; it did NOT require a wholesale review of the entire transmittal. The sum of the scores were then used to rank each transmittal within the themes that the Caucus voted on. We felt that it was important that the Caucus be able to weigh in on both the impact and urgency of the proposed resolutions, and figured a simple scoring metric like this one would help identify the Caucus' perspective on each transmittal without being too time-consuming. We did recognize that this system is inherently biased against older transmittals, as those were likely retained in the queue because they have been judged in the past to have a lower impact and/or less urgency; therefore, we felt including a score that incorporates how long a resolution is left in the queue would help correct for that bias.

3. The SDs then created two options for the Preliminary Transmittal Calendar: Option A was to rank transmittals by their theme priority score, then their timeliness score and Option B was to rank transmittals by their timeliness score then their theme

priority score. Both options were sent to the Caucus and an extraction form was sent to allow for more discussion on the rankings.

4. The Caucus held a meeting On September 15, 2022 which to decide upon the final transmittal list. It was decided to go with Option B for our Transmittal Calendar. Any member was able to extract an item and suggest its addition or removal from the final transmittal list. At the end of this meeting, 38 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2022–2023 Section Delegates executed this transmittal plan according to the Annual 2022
Transmittal Calendar (Appendix 1). On September 19, 2022, your 2022-2023 Section Delegates submitted 10 resolutions from A-22 that had not previously been submitted for consideration to the House. Your Section Delegates submitted the remaining 28 “on-time” resolutions to the House before the deadline of October 13, 2022. Notably, due to a clerical error, nine resolutions were submitted to the House of Delegates with either incorrect whereas or resolve clauses. Your Section Delegates and MSS Caucus made every effort to return to the correct, Assembly-adopted language for each of the mismatched items, but were unsuccessful for four of those items. Your Section Delegates recommend re-transmittal of those incorrectly transmitted resolutions to ensure the will of the Assembly is properly discharged (see “Recommendations” below).

Current Meeting: Annual 2023

The Annual 2023 Meeting is scheduled as an in person meeting to take place in Chicago, IL from June 7-14, 2023. Like the previous meeting, your Section Delegates went through the pending transmittal list and discussed the best way to move forward in an effort to clear our section’s backlog. For this effort, your Section Delegates followed a strict timeline to effectively choose which transmittals should be sent to the House of Delegates for the A-23 Meeting. This process was the same that was followed at the I-22 meeting but in the effort to increase transparency in this process, there were additions that will be outlined below:

5. First, one of the new additions to the transmittal process was soliciting comments on our transmittals from the Assembly. Your Section Delegates created a public facing repository of the current transmittal queue and shared it widely to the MSS so that they may share their thoughts and concerns, as well as help current and future Section Delegates to correct for any mistakes that may be overlooked.
6. After the commentary phase concluded, the theme prioritization process (as done for the A-22 cycle) was utilized. Your Section Delegates assigned one of 28 themes to each resolution, after which Caucus members were asked to vote on the order in which these themes should be considered priority.

7. Concurrently, the timeliness prioritization process (as introduced in the I-22 cycle) was utilized. Your Section Delegates asked Caucus members to score each resolution by three characteristics, each on a 1|2|3 point scale. The sum of these scores were added up and used to rank resolutions (minimum score of 3, maximum of 9). Those characteristics were as follows:

    Impact (to be scored by the Caucus):

    - 3 - High impact
        - Substantial change to policy OR fills a massive gap
        - Impacts a large group or has a profound impact on a smaller group
    - 2 - Moderate impact

    - Changes policy or fills a gap that impacts a core issue
    - Has a small impact on a large group or impacts a smaller group
- 1 - Low impact
    - Unlikely to substantially change AMA advocacy OR effect will be limited

Urgency (to be scored by Caucus):

- 3 - High urgency
    - Failure of AMA to act NOW may lead to irreparable harm to the ISSUE
        - Note that this does not consider the impact that acting on this issue may have, but only whether failure to act now will preclude future action!
- 2 - Moderate urgency
    - AMA engagement would materially assist the ISSUE in the short term but would not cause irreparable harm if there was no action
- 1 - Low urgency
    - AMA action can be delayed indefinitely without causing harm to advocacy on the issue

Length of time in queue:

- 3 - Passed in I-20 or before
- 2 - Passed in A-21 or I-21
- 1 - Passed in A-22

For the criteria listed as reviewed by the Caucus, we randomly assigned 10 transmittals per person to score for urgency and impact. Note that these were *just based on the resolved clauses*; it did NOT require a wholesale review of the entire transmittal. The sum of the scores were then used to rank each transmittal within the themes that the Caucus voted on. We felt that it was important that the Caucus be able to weigh in on both the impact and urgency of the proposed resolutions, and figured a simple scoring metric like this one would help identify the Caucus' perspective on each transmittal without being too time-consuming. We did recognize that this system is inherently biased against older transmittals, as those were likely retained in the queue because they have been judged in the past to have a lower impact and/or less urgency; therefore, we felt including a score that incorporates how long a resolution is left in the queue would help correct for that bias.

8. The SDs then created a Preliminary Transmittal Calendar using a composite of the following ranking options: Option A was to rank transmittals by their theme priority score, then their timeliness score and Option B was to rank transmittals by their timeliness score then their theme priority score. The final ranking in the Preliminary Transmittal Calendar was achieved by adding the ranks from each method and sorting in ascending order. For example, if T120 was ranked 1 under method 1 and 6 under method 2, it would get a net score of 7. Score by timeliness then theme (Option B) used to break ties (i.e., if T120 and T160 had a net score of 7 but T160 had a method 1 rank of 6, then T120 was ranked higher. This was sent along to the Caucus and an extraction form was sent to allow for more discussion on the rankings.

9. The Caucus held a meeting on February 20, 2023 which decided upon the final transmittal list. Any member was able to extract an item and suggest its addition or removal from the final transmittal list. At the end of this meeting, 65 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2022–2023 Section Delegates executed this transmittal plan according to the Annual 2023 Transmittal Calendar (Appendix 1). On April 5, 2023 your 2022-2023 Section Delegates submitted 63 resolutions to the House before the deadline of May 12,2023. The remaining will be sent to the House at the conclusion of the MSS Section Meetings, the reasonings being explained in Appendix 2.

CONCERNS WITH A GROWING TRANSMITTAL QUEUE

The MSS Governing Council (GC) welcomes the increased interest in our MSS policy process and Assembly, and encourages students to submit resolutions advocating on issues which are important to them. However, several stakeholders have raised concerns about the growing transmittal queue. These concerns include:

- Insufficient time for adequate discussion of resolutions in the House of Delegates, including the bandwidth to garner external support for each resolution and potential dilution of MSS capital
- Timeliness of resolutions once they are transmitted, especially if left in queue beyond the standard 6-month period between national meetings
- Increasing impact on student leadership (including section and region delegates as well as the House Coordinating Committee) in regard to reviewing business items, preparing testimony, and defending MSS-authored resolutions, most of which cannot increase in size due to our bylaws
- Impact on AMA staff (including MSS staff, legal review, and advocacy review), who offer their feedback while concurrently preparing for the HOD and maintaining advocacy responsibilities

Table 1 shows the trend in MSS-authored resolutions discussed at each House of Delegates, and the ratio of MSS-authored to total number of HOD resolutions. (*Note that the idea of limiting the number or imposing additional thresholds for external resolutions has been considered by the 2018 MSS Resolutions Task Force, but was ultimately not recommended due to concerns on restricting the democratic process. Further, the MSS has tried restricting resolutions considered by a Resolutions Committee in the recent past and found that the exercise did not ultimately reduce the amount of time or effort required for the resolutions process*.

Meeting	Total No. of MSS Authored Resolutions	Total No. of HOD Resolutions	Ratio of MSS/HOD
A-06	13	-	-
I-06	4	-	-
A-07	12	254	4.72%

I-07	8	90	8.89%
A-08	13	239	5.44%
I-08	5	99	5.05%
A-09	10	224	4.46%
I-09	10	90	11.11%
A-10	14	198	7.07%
I-10	17	98	17.35%
A-11	23	189	12.17%
I-11	21	108	19.44%
A-12	29	216	13.43%
I-12	12	76	15.79%
A-13	17	179	9.50%
I-13	6	88	6.82%
A-14	13	200	6.50%
I-14	17	110	15.45%
A-15	16	199	8.04%
I-15	13	93	13.98%
A-16	17	185	9.19%
I-16	20	103	19.42%
A-17	19	197	9.64%
I-17	14	102	13.73%
A-18	31	200	15.5%

I-18	12	98	12.2%
A-19	23	232	9.9%
I-19	30	98	30.6%
A-20 **No policy discussion	(41 in queue)	N/A	-
I-20 **Special Meeting	9 transmitted, 5 considered	36 considered	13.9%
A-21 **Special Meeting	(started with 101 in queue) 40 transmitted,16 considered	66	24.2%
I-21 **Special Meeting	(started with 105 in queue) 54 transmitted, 13 considered	39	33.3%
A-22	(started with 113 in queue) 50 transmitted	232	21.6%
I-22	(started with 74 in queue) 42 transmitted, 27 considered, 2 withdrawn	134	20.15%
A-23	(started with 88 in the queue) 65 transmitted	TBD	TBD%
MSS Average			**13.50 %** (24.81% within the past 4 meetings)

TIMELINESS OF QUEUED TRANSMITTALS

Your Section Delegates and MSS Governing Council recognize the importance of finding a democratic solution that allows our Section to contribute meaningfully to the policy-making process of the AMA, and the capacity of our MSS Caucus to adequately defend each policy proposal brought forth to the HOD.

Appendix 2 of this report outlines the remaining transmittals along with a recommendation and supporting rationale where appropriate. Specifically, your Section Delegates sought to clarify whether the ask (1) remains timely and (2) has otherwise been carried out by the organization. If it was determined that a resolution's proposed policy has been accomplished elsewhere within the AMA, then your Section Delegates interpret transmission to the House of Delegates to be unnecessary as there would be no future "appropriate meeting" where such policy be considered timely, novel, or necessary to guide the AMA's operations or advocacy. In those resolutions, detailed justifications will be provided for the Assembly's consideration. **Appendix 3** of this report lists the resolutions to be transmitted to the House of Delegates at the Annual 2023 meeting. **Appendix 4** of this report gives the themes extracted from the current MSS pending transmittals with their rank and mean ranking. Note that Caucus votes to combine transmittals occurred after the ranking process.

Regardless of transmittal status, all policies shall be retained in the AMA-MSS Digest of Actions until sunset review. Individuals or organizations seeking support for a particular issue will have this available to reference.

RECOMMENDATIONS

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:

1. 132 Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
2. 37 Amending G-630.140, Lodging, Meeting Venues, and Social Functions
3. 127 Supporting Daylight Saving Time as the New, Permanent Standard Time
4. 143 Amending Policy on a Public Option to Maximize AMA Advocacy

Your Section Delegates recommend the transmittal of the following resolutions due to the mismatch of final resolved clauses sent at the I-22 meeting:

1. 53 Supporting the Use of Gender-Neutral Language
2. 73 Environmental Sustainability of AMA National Meetings
3. 152 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions

Your Section Delegates further recommend that the following resolutions be combined:

1. 148 The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly to 174 Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients (New Title: Increasing Usability of Health Information Technology (HIT))
2. 160 Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid; 130 Establishing Comprehensive Dental Benefits Under State Medicaid Programs; 223 Medicaid Hearing Coverage (New Title: Medicaid Benefit Expansion)
3. 109 Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine; 245 Advocating for Access to Safer Smoking Kits as Part of Harm Reduction Services (New Title: Supporting Harm Reduction)
4. 257 Expansion of Medicaid Coverage of HPV Screening (CEQM WIM Report A); 222 Preventing Human Papillomavirus (HPV) Infection and HPV-Associated Cancers in People Who Are Incarcerated (New Title: Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers)

5. 202 Access to Naloxone for Vulnerable and Underserved Populations; 229 Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression (New Title: Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations)

Your Section Delegates further recommend the following resolutions be amended as indicated:

1. 73 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
2. 94 Hospital Bans on TOLAC
3. 216 New Policies To Respond To The Gun Violence Public Health Crisis
4. 238 Environmental Health Equity In Federally Subsidized Housing

Your Section Delegates further recommend that the following resolutions be held in the queue for the duration of the current meeting due to other ongoing movement on related items:

1. 160 Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid; 130 Establishing Comprehensive Dental Benefits Under State Medicaid Programs; 223 Medicaid Hearing Coverage
2. 107 Abolishment of the Resolution Committee

Appendix 1: Transmittal Calendars

November 2020 Meeting

Dates	Event
Aug 14th (Fri)	Release I-2020 Transmittal Calendar to MSS Caucus.
Aug 19th (Wed)	I-2020 Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Aug 21st (Fri)	Release summarized list of potential themes for Caucus to vote.
Aug 25th (Tue)	Deadline to vote for I-2020 Transmittal Focus Priorities @ 11:59pm CT.
Aug 26th (Wed)	I-2020 Transmittal Focus Priorities released to MSS Caucus.
Aug 28th (Fri)	Announce Transmittal Focus Priorities to I-2020 Transmittal Authors. Release Google Form for authors and MSS Caucus to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (300 characters max).
Sept 5th (Sat)	Deadline for transmittal authors and MSS Caucus to comment on resolutions @ 11:59pm CT.
Sept 6th (Sun)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Sept 18th (Fri)	Transmittal Scoring Deadline @ 11:59pm CT.
Sept 21st (Mon)	Release list of I-2020 Final Resolutions asking for immediate forwarding to Caucus for review.

Sept 24th (Thu)	MSS Caucus Town Hall to discuss the I-2020 Resolutions @ 8pm CT.
Sept 25th (Fri)	Release “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall. Notify transmittal authors of decision.
Sept 30th (Wed)	MSS Caucus Town Hall to discuss transmittals list @ 7pm CT. If planning to extract, please complete this form 24hrs before the Town Hall.
Oct.1st (Thu)	Submit I-2020 Transmittals to the House of Delegates

June 2021 Meeting

Dates	**Event**
Feb 21 (Sun)	MSS Caucus meeting to brainstorm transmittal process, including any potential changes.
Mar 13th (Sat)	Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Mar 14th (Sun)	Release summarized list of potential themes for Caucus to vote.
Mar 18th (Thu)	Deadline to vote for J-2021 Transmittal Focus Priorities @ 11:59pm CT.
Mar 19th (Fri)	Announce Transmittal Focus Priorities to J-2021 Transmittal Authors. Open Comment Period all MSS members to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (1000 characters max). Send resolutions for preliminary advocacy feedback.
Mar 28th (Sun)	Open Comment Period on MSS Transmittals closes @ 11:59pm CT.
Mar 29th (Mon)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Apr 10th (Sat)	Transmittal Scoring Deadline/Voting @ 11:59pm CT.
Apr 13th (Tue)	Release list of J-2021 Final Resolutions asking for immediate forwarding to Caucus for review.
Apr 23rd (Fri)	Release preliminary “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall.

Apr 25th (Sun)	MSS Caucus Town Hall to discuss transmittals list (MANDATORY) @ 3pm CT. Transmittal Calendar finalized following MSS Caucus Town Hall.
May 12th (Wed)	Deadline to submit J-2021 Transmittals (batch #1) to the House of Delegates

November 2021 Transmittal Calendar

Dates	Event
Aug. 10 (Tues)	First email to Caucus regarding transmittal process for upcoming meeting.
Aug. 26th (Thurs)	Section Delegates solicit feedback on previous transmittal processes and input on proposed ideas from Caucus.
Aug. 29th (Sun)	Release N-2021 Transmittal Calendar and Process to MSS Caucus. The N-2021 Transmittal Comments sheet was released and would remain open for the entirety of this process.
Sept. 5th (Sun)	Section Delegates release N-2021 Transmittal Themes for voting by MSS Caucus.
Sept. 7th (Tues)	MSS Town Hall to discuss N-2021 Transmittal Process. The event was open to all MSS members, recorded, and posted online.
Sept. 10th (Fri)	Deadline for MSS Caucus to vote on prioritization of N-2021 Transmittal Themes.
Sept. 16th (Thurs)	Section Delegates release Transmittal List, which included the preliminary N-21 Delegate Report plan, to the Caucus.
Sept 20-26th (Mon-Thu)	Extractions for changing the Transmittal list are open to the Caucus and due by 12 pm CT the day of the meeting.
Sept 26th (Sun)	MSS Caucus meeting to discuss the N-2021 Transmittal Consent Calendar.
Sept 27th (Mon)	Section Delegates release approved N-2021 Transmittal Consent Calendar
Sept. 30th (Thurs)	Deadline to submit N-2021 Transmittals to the House of Delegates

Annual 2022 Transmittal Calendar

Dates	Event
Feb.26 (Sat)	First email to Caucus regarding transmittal process for upcoming meeting.
March 8 (Tues)	Section Delegates solicit feedback on proposed ideas and previous transmittal processes from Caucus.
March 9 (Wed)	Release A-22 Transmittal Calendar and Process to MSS Caucus. Additionally, the A-22 Transmittal Comments is released and will remain open for the entirety of this process.
March 14 (Mon)	Section Delegates release A-22 Transmittal Themes for voting by MSS Caucus.
March 24 (Thu)	Deadline to vote on prioritization of A-22 Transmittal Themes by 11:59 PM PST
March 26 (Sat)	Section Delegates release A-22 Preliminary Transmittal Calendar to MSS Caucus.
March 26 thru April 4	Extractions (for removal from the calendar or addition to the calendar) will be due at the beginning of the meeting with justification.
April 4-5 (Mon– Tues)	MSS Caucus Town Hall to discuss the A-22 Transmittal Consent Calendar and additions (MANDATORY)
April 7 (Thurs)	Section Delegates release approved A-2022 Transmittal Consent Calendar to MSS Caucus and send previously-submitted transmittals to staff to be sent to the House of Delegates
April 8 (Fri)	Deadline to submit A-22 resubmissions to the House of Delegates
April 29 (Fri)	Section Delegates send “on-time” (never previously submitted) transmittals to staff to be sent to the House of Delegates
May 11 (Wed)	Deadline to submit A-22 “on-time” transmittals to the House of Delegates

Interim 2022 Transmittal Calendar

Dates	Event
Aug.21 (Sun)	First email to Caucus regarding transmittal process for upcoming meeting.
Aug 30 (Tues)	Section Delegates have first feedback on proposed ideas and previous transmittal processes from Caucus.
Aug 31 (Wed)	Section Delegates release I-22 Transmittal Themes for voting by MSS Caucus.
Sept 6 (Tues)	Deadline to vote on prioritization of I-22 Transmittal Themes by 11:59 PM PST
Sept 6 (Tues)	Section Delegates release I-22 Transmittal Timeliness scoring by MSS Caucus.
Sept 12 (Mon)	Deadline to score I-22 transmittals on timeliness by 11:59 PM PST
Sept 13 (Tues)	Section Delegates release I-22 Preliminary Transmittal Calendar to MSS Caucus.
Sept 13 thru Sept 15	Extractions (for removal from the calendar or addition to the calendar) will be due at the beginning of the meeting with justification.
Sept 15 (Thurs)	MSS Caucus Town Hall to discuss the I-22 Transmittal Consent Calendar
Sept 19 (Mon)	Section Delegates release approved I-2022 Transmittal Consent Calendar to MSS Caucus and send A-22 transmittals that have not been previously submitted to staff to be sent to the House of Delegates

Oct 13 (Thurs)	Deadline to submit I-22 “on-time” transmittals to the House of Delegates

A-23 Transmittal Calendar

Dates	Event
Jan 17	First email to Caucus regarding transmittal process for upcoming meeting, start soliciting comments on transmittals, this will remain open throughout the process
Jan 28	Send out A-23 transmittal themes and timeliness scores for voting
Feb 4	**Deadline to vote on prioritization of A-23 Transmittal Themes by 11:59 PM PST**
Feb 6	Section Delegates release A-23 Preliminary Transmittal Calendar to MSS Caucus.
Feb 6 thru Feb 21st	Extractions (for removal from the calendar or addition to the calendar) will be due at the beginning of the meeting with justification.
Feb 20-21	**MSS Caucus Town Hall to discuss the A-23 Transmittal Consent Calendar and additions (MANDATORY)**
Feb 22	Section Delegates release approved A-23 Transmittal Consent Calendar to MSS Caucus and send transmittals to staff to be sent to the House of Delegates
April TBD	Deadline to submit A-23 resubmissions to the House of Delegates
May TBD	Deadline to submit A-23 “on-time” transmittals to the House of Delegates

Appendix 2 – Recommendations for Pending MSS Transmittals to the House of Delegates

Transmittal	Recommendation
Reducing Costs of CMS Limited Data Sets for Academic Use RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3)**
Amending G-630.140, Lodging, Meeting Venues, and Social Functions RESOLVED, That our AMA amend AMA policy G-630.140 Lodging, Meeting Venues, and Social Functions be amended by addition as follows: LODGING, MEETING VENUES, AND SOCIAL FUNCTIONS, G-630.140 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. 4. It is the policy of our AMA not to hold <u>national</u> meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to,	**Discharge from transmittal queue** – A similar resolution was brought forward at the I-22 meeting, Resolution 602: Finding Cities for Future AMA Conventions/Meetings. The final HOD Action was to refer this resolution to allow our AMA Board of Trustees and its management team the opportunity to address any immediate decisions and to provide our House of Delegates with a report back at the I-23 Meeting that outlines options for the future, including but not limited to options for expanding potential venue choices, recommendations for possible policy changes, and the political ramifications of boycotting specific states.

policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. 5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.	
Supporting the Use of Gender-Neutral Language RESOLVED, That our AMA (1) Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity (2) Revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears (3) Utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used. (4) Encourage the use of gender-neutral language in public health and medical messaging (5) Encourage other professional societies to utilize gender-neutral language in their work (6) Support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals	**This item was one of the mismatched resolutions at I-22 and will be retransmitted to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Support for Mental Health Courts RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition and deletion as follows: SUPPORT FOR MENTAL HEALTH DRUG COURTS, H-100.955 Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

services and supports; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.	
~~Mitigating~~ Environmental ~~Contributors to Disease and~~ Sustainability of AMA National Meetings RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation; and be it further RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials; and be it further RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for members traveling to and from Annual and Interim meetings and report back to the House of Delegates; and be it further RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates~~; and be it further~~ ~~RESOLVED, That our AMA amend Policy D-135.997, "Research into the Environmental Contributors to Disease," by addition and~~	**This item was one of the mismatched resolutions at I-22 and will be retransmitted to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).** The stricken language was from a previous combination and will be instead re-combined with transmittal 238 ("Environmental Health Equity In Federally Subsidized Housing"), which is on a similar topic and is a better match for the language.

~~deletion to read as follows:~~ ~~D-135.997 RESEARCH INTO THE ENVIRONMENTAL CONTRIBUTORS TO DISEASE~~ AND ADVOCATING FOR ~~ENVIRONMENTAL JUSTICE~~ ~~Our AMA will (1) advocate for the greater public and private funding for research into the environment 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 and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies~~.	
Providing Reduced Parking Fees for Patients and Trainees RESOLVED, That our AMA works with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows: ~~REDUCING~~ OPPOSING THE USE OF RESTRICTIVE HOUSING ~~IN~~ FOR PRISONERS ~~WITH MENTAL ILLNESS~~ Our AMA will: (1) ~~support~~	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

~~limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions~~, for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, 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 safe, human, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. ~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~	
TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms RESOLVED, That our AMA amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows: TELEVISION BROADCAST AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994 The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.	
Encouraging Collaboration between Physicians and Industry in AI Development RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (1) Expanding recruitment among AMA physician members, (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas, (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies, (4) Facilitating communication between companies and physicians with similar interests, (5) Matching physicians to projects early in their design and testing stages, (6) Decreasing the time and workload spent by individual physicians on finding projects themselves, (7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Hospital Bans on TOLAC	**This item will be transmitted by our Section to**

~~RESOLVED, That our AMA encourage hospitals that can provide basic maternal care as defined by American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC); and be it further~~ ~~RESOLVED, That our AMA encourage hospitals that do not have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC.~~ RESOLVED, That our AMA supports the elimination of broad hospital-based restrictions that prevent physicians from offering a trial of labor after cesarean to their patients when medically appropriate; and be it further RESOLVED, That our AMA encourage hospitals to establish clear and transparent policies on trial of labor after cesarean in order to improve the process of patient-physician shared decision-making	**the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).** This item was withdrawn at the I-22 meeting after significant consideration from the American College of Obstetricians and Gynecologists (ACOG) delegation due to its problematic language. After further discussion and collaboration with the ACOG delegation, your Section Delegates proposed the following alternative language, intended to address the concerns raised by the ACOG delegation that would almost certainly prove fatal to the resolution in the House of Delegates. Specifically, the ACOG delegation was concerned that the first resolve clause might place undue pressure on hospitals whose available resources, including appropriate staffing, were insufficient for management of TOLAC. Further, the ACOG delegation was extremely concerned about the feasibility and safety of encouraging hospitals to assist in the transfer of patients to TOLAC-competent care centers, particularly in rural communities where such a transfer could take hours. Your Section Delegates engaged with the ACOG delegation productively to develop the following alternate resolve clauses, which advance the spirit of the original language by supporting increased access and transparency so that patients who desire TOLAC will have appropriate access and will be able to easily identify hospitals that offer it. Notably, both resolve clauses were written with direct ACOG input.
Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of Opioid Drug overdoses.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation RESOLVED, That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Supporting Harm Reduction *109 Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine:* RESOLVED, That our AMA advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and be it further RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine; and be it further *245 Advocating for Access to Safer Smoking Kits as Part of Harm Reduction Services:* RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows: Prevention of Drug-Related Overdose, D-95.987 1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate. 2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose. 3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures. 4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking, and injection drug preparation, use, and disposal supplies. 5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19. 6. Our AMA advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strips, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction.	
Abolishment of the Resolution Committee RESOLVED, That our AMA abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion: ~~Resolution Committee, B-2.13.3~~ ~~The Resolution Committee is responsible for~~	**Retain in transmittal queue** – This is still an ongoing issue being discussed by the BOT and AMA. Given the volume of resolutions our MSS is transmitting to the HOD this cycle, our MSS Caucus voted to wait to transmit this item, which is likely to be controversial.

~~reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~ ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~ ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~ ~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~ ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings.~~ ~~Action may be taken by written or electronic communications.~~ ~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an~~ ~~Interim meting upon majority vote of committee members voting. The~~ ~~Speaker shall only vote in the case of a tie. If a resolution is not accepted,~~ ~~it may be submitted for consideration at the next Annual Meeting in~~ ~~accordance with the procedure in Bylaw 2.11.3.1.~~ ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of~~ ~~the committee shall be presented to the House of Delegates at the call of~~ ~~the Speaker.~~	
Increase Employment Services Funding to People with Disabilities RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Formal Transitional Care Program for Children and Youth with Special Healthcare Needs RESOLVED, That our AMA amend policy H-60.974, Children and Youth with Disabilities, by	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

addition and deletion as follows, to strengthen our AMA policy and to include 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: H-60.974 – CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDS 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 health care 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.	
Exclusion of Race and Ethnicity in the First Sentence of Case Reports RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

from the first sentence of case reports and other medical documentation; and be it further RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation.	
Regulation of Phthalates in Adult Personal Sexual Products RESOLVED, That AMA H-135.945 be amended by addition and deletion as follows: H-135.945 – ENCOURAGING ALTERNATIVES TO PVC/PHTHALATE ~~DEHP~~ PRODUCTS IN HEALTH Our AMA: (1) Encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) ~~medical device~~ products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) Urges expanded manufacturer development of safe, cost-effective alternative products to PVC ~~medical device~~ products, especially those containing phthalates such as DEHP~~.~~; and (3) Encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal consumer products, including adult personal sexual products, as a source of phthalates; and (4) Supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Supporting Daylight Saving Time as the New, Permanent Standard Time RESOLVED, That our AMA recognize the adverse	**Discharge from transmittal queue** – A similar resolution was brought forward at the I-22 meeting, Resolution 210: Elimination of Seasonal Time Changes and Establishment of Permanent

health effects of biannual time changes and support the elimination of biannual time changing; and be it further RESOLVED, That our AMA recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time.	Standard Time. This resolution ultimately passed and now Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time H-440.802 states that our AMA supports " the elimination of seasonal time changes; and (2) the adoption of year-round standard time."
Medicaid Benefit Expansion *130 Establishing Comprehensive Dental Benefits Under State Medicaid Programs:* RESOLVED, That our AMA amend H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows: **H-330.872 - MEDICARE, MEDICAID, AND OTHER PUBLIC HEALTH INSURANCE COVERAGE FOR DENTAL SERVICES** Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, ~~and~~ Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in both~~ Medicare, and Medicaid, ~~and~~ other public health insurance program beneficiaries ~~populations~~, the optimal dental benefit plan designs to cost effectively improve health and prevent disease ~~in both~~ among Medicare, ~~and~~ Medicaid, and other public health insurance program beneficiaries ~~populations~~, and the impact of expanded dental coverage on health care costs and utilization. *160 Support Vision Screenings and Visual Aids for Adults Covered by Medicaid:* RESOLVED, That our AMA advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and	**Retain in transmittal queue** – Our MSS Caucus voted to retain this in the queue as there is an upcoming report from the Council on Medical Service on a similar topic (Medicare benefit expansion). The MSS Caucus decided to wait to see the contents of said report before transmitting this item. Recommend combination of these items as shown, as they are on similar topics.

any new public insurance programs. *223 Medicaid Hearing Coverage:* RESOLVED, That our AMA amend H-185.929 by addition to read as follows: Hearing Aid Coverage H-185.929 1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids. 2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear. 3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services. 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit. 5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly. 6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids. 7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. <u>8. Our AMA advocate that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid programs and any new public insurance programs.</u>	
Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates RESOLVED, That our AMA update its Special Meeting procedures by updating the Special	**Discharge from transmittal queue** - There was a similar Board of Trustees report submitted at the I-22 meeting, Board of Trustees Report 8 - The Resolution Committee as a Standing Committee of the House. BOT Report 8 asked to prepare a

Meetings Bylaws as follows: 1. Specification that the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates prior to the initiation of the Special Meeting. 2. Specification concerning the processes for how formal feedback may be submitted and reviewed prior to, during, and after the conclusion of the Special Meeting. 3. Description of how a Special Meeting report, detailing the processes that were used in the meeting, along with a summary of the concerns and suggestions submitted by the formal feedback mechanism, shall be produced by the Speakers and Board of Trustees following each Special Meeting that occurs. 4. Description of how, after each Special Meeting, a committee that is representative of House membership shall be formed for the purpose of (a) reviewing the Special Meeting and (b) proposing any improvements to the processes for future Special Meetings.	report for consideration at the 2023 Annual Meeting recommending a trial of a resolution committee, including the make-up and operation of the committee and create measures of fairness and effectiveness of the trial.The HOD action was to not adopt the report, More details can be found on the I-22 Annotated Reference Committee F report.
Movement Away from Employer-Sponsored Health Insurance RESOLVED, That our AMA recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare; and be it further RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer sponsored health insurance and enables universal access to high quality healthcare; and be it further RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability,” by addition and deletion to read as follows: H-165.828 – HEALTH INSURANCE AFFORDABILITY 1. ~~Our AMA supports modifying the eligibility~~	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

~~criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~ Our AMA advocates for the elimination of the employer sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance. 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible. 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost sharing responsibilities for common procedures and services. 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health	

Savings Account (HSA) with information on how to set up an HSA. RESOLVED, That our AMA amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform,” by addition and deletion to read as follows: H-165.823 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM 1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. ~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~ b~~c~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements. e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. fg. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for	

premium tax credits – at no or nominal cost. 2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations. b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto enrollment. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost sharing reductions, and establishing a special enrollment period	

Drug Policy Reform RESOLVED, That our AMA advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug related felonies; and be it further RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individuals; and be it further RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession; and be it further RESOLVED, That our AMA-MSS forward this resolution to a future House of Delegates meeting taking place after the HOD considers its upcoming report pursuant to D-95.960 Public Health Impacts of Cannabis Legalization.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Amending Policy on a Public Option to Maximize AMA Advocacy RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform," by addition and deletion as follows: H-165.823 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM 1. Our AMA will advocate ~~that any~~ for a public option to expand health insurance coverage ~~must~~ that meets the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan market place competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets	**Discharge from transmittal queue** – A similar resolution was brought forward at the I-22 meeting, Resolution 813: Amending Policy on a Public Option to Maximize AMA Advocacy. The final HOD Action was to adopt an alternate resolution in lieu of the submitted language. H-165.823 has been amended to include the following: "That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians." For more details please refer to the Annotated I-22 Reference Committee J report.

standards for minimum value of benefits. c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. e. The public option is financially self-sustaining and has uniform solvency requirements. f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans. g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost. 2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations. b. Individuals should only be auto-enrolled in health	

insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto enrollment. e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost sharing reductions, and establishing a special enrollment period.	

Increasing Usability of Health Information Technology (HIT) *148 The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly:* RESOLVED, That our AMA support the development of a standardized definition of "age-friendliness" in health information technology (HIT) advancements; and be it further RESOLVED, That our AMA encourage the appropriate stakeholders to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults. *174 Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients:* RESOLVED, That our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA. Recommend combination of these similar items to consolidate the MSS transmittal queue.
AMA Study of Chemical Castration in Incarceration RESOLVED, That our AMA study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Evaluating Clinical Outcomes of Mobile Health Technology RESOLVED, That our AMA amend D-480.972, "Guidelines for Mobile Medical Applications and Devices," by addition as follows: D-480.972 – GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES 1. Our AMA will monitor market developments in mobile health	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

(mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement. 2. Our AMA will monitor and report on how mHealth apps and devices impact patient outcomes, especially in patient populations at whom interventions may be targeted, such as those managing chronic diseases and consumers seeking healthier lifestyles. ~~2.~~ 3. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful, and trustworthy mHealth market. ~~3.~~ 4. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based. ~~4.~~ 5. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications. ~~5.~~ 6. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows. ~~6.~~ 7. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more	

uniform regulation for use of mobile devices in medical education and clinical training. ~~7.~~ 8. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments. ~~8.~~ 9. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.	
Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs and Reduce Evictions "Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs" by addition and deletion to read as follows: Eradicating Homelessness, H-160.903 Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local	**This item was one of the mismatched resolutions at I-22 and will be retransmitted to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

resources are necessary to address this societal problem on a long-term basis; (4) supports the use of 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; (~~4~~5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; (~~5~~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; (~~6~~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; (~~7~~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; (~~8~~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; (~~9~~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 (~~10~~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~~..~~; and (12) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries.	
Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures RESOLVED, That our AMA recognizes the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process; and be it further RESOLVED, That our AMA supports further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Supporting Intimate Partner And Sexual Violence Safe Leave RESOLVED, That our AMA recognize the positive impact of paid safe leave on public health	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

outcomes and support legislation that offers safe leave; 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 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; (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 limited to intimate partner violence, sexual violence or coercion, and stalking. 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.	
Interrupted Patient Sleep RESOLVED, Our AMA encourages physicians, trainees, inpatient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be performed at another time; and be it further RESOLVED, Our AMA support efforts to improve quality, duration, and timing of inpatient sleep.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population RESOLVED, That our AMA supports the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; and be it further RESOLVED, That our AMA recognizes that stable housing promotes adherence to HIV treatment; and be it further RESOLVED, That our AMA amend current policy HIV/AIDS as a Global Public Health Priority H-20.922 to state the following **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	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

HIV/AIDS epidemic; (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, and access to stable housing 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 and financial assistance for 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.	
Inclusion of Disability in Medical Student Mistreatment Reporting	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

RESOLVED, Our AMA will work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire.	
Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis RESOLVED, That our AMA supports research towards the evaluation and the development of interventions and programs for autistic individuals; and be it further RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism; and be it further RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" as follows: Standardizing Coverage ~~of Applied Behavioral Analysis Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921 Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ services for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy.~~	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Amending Policy H-525.988, “Sex and Gender Differences in Medical Research” RESOLVED, Our AMA amend Policy H-525.988, “Sex and Gender Differences in Medical Research,” as follows: Sex and Gender Differences in Medical Research, H-525.988 Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large; (2) affirms the need to include ~~both~~ all genders in	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

studies that involve the health of society at large and publicize its policies; (3) supports increased funding into areas of women's health and sexual and gender minority health research; (4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative~~.~~; (6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities (7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities.	
Promoting a Fragrance-Free Health Care Environment RESOLVED, Our AMA recognizes fragrance sensitivity as disability where the presence of fragranced products can limit accessibility of healthcare settings; and be it further RESOLVED, Our AMA encourages all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind; and be it further RESOLVED, Our AMA will work with relevant stakeholders to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

(OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care.	
Recognizing The Burden Of Rare Disease RESOLVED, That our AMA recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases; and be it further RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Increasing the Availability of Automated External Defibrillators RESOLVED, That our AMA 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	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

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.	
SNAP Expansion for DACA Recipients RESOLVED, That our AMA will actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).** This resolution has not been sent to the House of Delegates yet as there is a pending MSS resolution that aims to amend this transmittal. It will be forwarded to the HOD at the conclusion of the MSS meeting.
Reforming The Medicare Part B “Buy And Bill” Process To Encourage Biosimilar Use	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of**

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation.	**Delegates (please see Appendix 3).**
Study Integrating Comparative Effectiveness Research into the FDA Approval Process RESOLVED, That our AMA study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter; and be it further RESOLVED, That our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Protecting Workers During Catastrophes RESOLVED, That our AMA will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes; and be it further RESOLVED, That our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes.	
Incorporating Holocaust Education in Medical Schools on International Remembrance Day RESOLVED, Our AMA host an annual event in support of International Holocaust Remembrance Day (January 27) to provide education to medical trainees about the role of physicians in the Holocaust.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations *202 Access to Naloxone for Vulnerable and Underserved Populations:* RESOLVED, That our AMA amend Increasing Availability of Naloxone H-95.932 as follows: 1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration. 8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators. 9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. 10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order Naloxone to help prevent opioid-related overdose, especially in underserved communities and American Indian reservations. and be it further RESOLVED, That our AMA amend Policy H-420.950, "Substance Use Disorders During Pregnancy" by addition and deletion to read as follows: Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected, and (5) support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits. *229 Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression:*	

RESOLVED, That our AMA amend D-95.987 by addition:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drugrelated overdose; (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with

having a substance use disorder and a serious respiratory illness such as COVID-19. 6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.	
Supporting Further Study of Kratom RESOLVED, That policy H-95.934 be amended by addition and deletion as follows: Kratom and its Growing Use Within the United States H-95.934 Our AMA: supports ~~legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.~~ efforts to further study the clinical uses, benefits, and potential harms of Kratom, and oppose efforts that may restrict research.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
National Fertility Coverage Mandate RESOLVED, That our AMA amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage” by addition and deletion to read as follows: 1. Our AMA ~~encourages third party payer health insurance carriers to make available insurance benefits~~ supports federal protections that ensure insurance coverage by all payers for the diagnosis and treatment of recognized ~~male and female~~ infertility. 2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Addressing Inequity in Onsite Wastewater Treatment RESOLVED, That our AMA supports that federal, state, and local governments abate individual	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities and American Indian reservations due to environmental racism and socioeconomic disparities; and be it further RESOLVED, That our AMA supports research by federal, state, and local governments to develop strategies to reduce insufficient wastewater management and eliminate detrimental health effects due to inadequate wastewater systems.	
Indian Health Service Licensure Exemptions RESOLVED, Our AMA will advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed; and be it further RESOLVED, Our AMA will advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Support for Research on Plant-Based Meat RESOLVED, That our AMA works with appropriate stakeholders to support plant-based meat research funding.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Tribal Public Health Authority RESOLVED, Our AMA advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities; and be it further RESOLVED, Our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

Public Health and Tribal affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and be it finally RESOLVED, Our AMA encourages the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.	
Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to Include Medical Professionals as a Party Who Can Petition the Court RESOLVED, That our AMA work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws; and be it further RESOLVED, That our AMA will work with relevant stakeholders to update medical curricula with training surrounding how to approach conversations about Extreme Risk Protection Order/Red Flag laws with patients and families; and be it further RESOLVED, That our AMA supports amending policy “Firearms and High-Risk Individuals H145.972” by addition to read: **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	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

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.	
Purchased and Referred Care Expansion RESOLVED, That our AMA will advocate to Congress to 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs; and be it further RESOLVED, That our AMA encourages nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Increased Education and Access to Fertility Resources for U.S. Medical Students RESOLVED, Our AMA will work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees; (3) the high rate of infertility among medical students, trainees, and physicians;	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and be it further RESOLVED, Our AMA will work with relevant organizations to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.	
Medicaid Managed Care for Indian Health Care Providers RESOLVED, That our AMA urges stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with their legal obligations to Indian health care providers; and be it further RESOLVED, That our AMA collaborates with other stakeholders to encourage state Medicaid agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers by, including, but not limited to: 1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid agencies. 2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian Managed Care Addendum. 3. Offering employee onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Supporting Legislative and Regulatory Efforts Against Fertility Fraud RESOLVED, That our AMA opposes physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

fertility fraud; and be it further RESOLVED, That our AMA supports legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent.	
New Policies to Respond to the Gun Violence Public Health Crisis ~~RESOLVED, That our AMA support evidence-based community firearm violence interruption programs and hospital-based violence interruption programs; and be it further~~ RESOLVED, That our AMA advocate for federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; and be it further RESOLVED, That our AMA advocate for federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and be it further RESOLVED, That our AMA advocate for federal and state policies implementing background checks for ammunition purchases.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).** The first resolved clause is discharged as a result of the language in BOT Report 2: Further Action to Respond to the Gun Violence Public Health Crisis from the I-22 Meeting, that was adopted as amended and filed. As a result, Further Action to Respond to the Gun Violence Public Health Crisis D-145.992 states that our AMA "will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) ***support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics;*** (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence."
Tribal Health Program Electronic Health Record Modernization RESOLVED, That our AMA supports adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

Amending Access to Confidential Health Services for Medica Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents RESOLVED, that AMA policy H-295.858 be amended to read as follows: **Access to Confidential Health Services for Medical Students and Physicians H-295.858** 1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

their mental and physical health and wellbeing, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle. 2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. 3. Our AMA encourages ~~medical schools~~ undergraduate and graduate medical programs to create mental health and substance abuse awareness and suicide prevention screening programs that would: A. be available to all medical students, residents, and fellows on an opt-out basis B. ensure anonymity, confidentiality, and protection from administrative action; C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. 4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate	

that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education. 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.	
Reconsideration of the Birthday Rule RESOLVED, That our AMA support evidence-based legislation that support a parent, or	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

guardian's, choice of their dependent's health insurance plan under the event of multiple insurers; and be it further

RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition as follows:

Delay in Payments Due to Disputes in Coordination of Benefits, H190.969
Our AMA:
(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
(2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;
(6) through its Advocacy Resource Center, continue to coordinate and implement the timely

payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and (7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.	
Indian Health Service Graduate Medical Education RESOLVED, That our AMA advocate for the establishment of an Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs; and be it further RESOLVED, That our AMA supports the development of novel graduate medical education (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Estrogen as a Risk Factor for Stroke in Patients with Migraine with Aura RESOLVED, That our AMA support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in, inclusive of but not limited to: combined oral contraceptive pills, vaginal rings, transdermal patches, hormone replacement therapy, and gender affirming hormone therapy in individuals with migraine and migraine with aura; and be it further RESOLVED, That our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment,	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

when indicated, of migraine and migraine with aura consistent with current diagnostic guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and gynecology, endocrinology, neurology, and cardiology clinics.	
Amending Policy H-80.999, “Sexual Assault Survivors” to Improve Knowledge and Access to No-Cost Rape Test Kits RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault Survivors,” by addition to read as follows: **Sexual Assault Survivors, H-80.999** 1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors. 2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention. 3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

established for this purpose under the Survivor's Bill of Rights Act of 2016. 4. Our AMA will (a) advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; (b) support and advocate that appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, create and implement a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers. 5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.	
Billing for Traditional Healing Services RESOLVED, The AMA will study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native healing practices provided in concert with physician-led healthcare teams.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Special Diabetes Program for Indians RESOLVED, Our AMA supports permanent reauthorization of the Special Diabetes Program for Indians; and be it further RESOLVED, Our AMA supports biannual inflationary increases for public health and health profession grants sponsored by the Indian Health Service.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Research of Plastic Use in Medicine RESOLVED, That our AMA amend by addition as follows:	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

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; <u>(14) encourages research into the effects of microplastics on human health;</u> (14<u>5</u>) encourages physician educators in medical schools, residency	

programs, and continuing medical education sessions to devote more attention to environmental health issues; (1~~5~~6) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (1~~6~~7) encourages expanded funding for environmental research by the federal government; and (1~~7~~8) encourages family planning through national and international support.	
Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training RESOLVED, That our AMA supports use of diverse mannequins in CPR and AED training, including, but not limited to, mannequins with breasts, mannequins representing pregnant persons, mannequins representing persons with disabilities, and mannequins of varying body sizes; and be it further RESOLVED, That our AMA supports the efforts of relevant stakeholders to develop diverse mannequins or modify current mannequins to reflect diverse patient populations, including, but not limited to, those representing pregnant persons or persons with physical disabilities; and be it further RESOLVED, That our AMA will collaborate with relevant stakeholders to increase accessibility of CPR and AED training equipment representing diverse gender and body types in basic life support and advanced certified life support programs nationwide to ensure optimal competency for trainees of all education levels.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
The Health Care Related Effects of Recent Changes to the US Mexico Border RESOLVED, That our AMA recognizes the health related effects and humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant populations and the resulting effects on	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

the U.S. healthcare system; and be it further RESOLVED, That our AMA oppose efforts to increase the height or length of border walls and fences at the US-Mexico border, and other policies that deter people from crossing the border by increasing or creating risks to their health and safety.	
Conservatorship and Guardianship Reform RESOLVED, That our AMA support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse; and be it further RESOLVED, That our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Advocating for the Regulation of Waste Products in Industrialized Farming RESOLVED, That our AMA recognizes Concentrated Animal Feeding Operations (CAFOs) as a public health hazard; and be it further RESOLVED, That our AMA encourage the EPA and appropriate stakeholders to remove the regulatory exemptions for CAFOs under EPCRA and CERCLA and tighten restrictions on pollution from CAFOs.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Emergency Anti-Seizure Interventions RESOLVED, That our AMA support efforts in the recognition of status epilepticus and bystander intervention trainings; and be it further RESOLVED, That our AMA encourage physicians to educate patients and families affected by epilepsy on status epilepticus and work with patients and families to develop an individualized	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

action plan for possible status epilepticus, the which may include distribution of home pharmacotherapy for status epilepticus, in accordance with the physician's best clinical judgment.	
Studying Population-Based Payment Policy Disparities RESOLVED, That our AMA study opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas; and be it further RESOLVED, That our AMA study the effects of factors such as valuation and reimbursement rates on physician choice of specialty, degree of institutional support, workforce shortages, burnout, and attrition, especially in specialties and practice settings that primarily care for underserved populations.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
School-To-Prison Pipeline RESOLVED, That our AMA amend Policy H-60.900, Student-Centered Approaches for Reforming School Disciplinary Policies, by addition and deletion 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	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

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.	
Environmental Health Equity In Federally Subsidized Housing RESOLVED, That our AMA acknowledge the potential adverse health impacts of living in close proximity to a Superfund site; 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; and be it further RESOLVED, That the 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**; and be it further** **RESOLVED, That our AMA amend Policy D-135.997, "Research into the Environmental Contributors to Disease," by addition and deletion to read as follows:** **D-135.997 – ~~RESEARCH INTO THE~~ ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE** **Our AMA will (1) advocate for the greater public**	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).** The language in bold represents an amendment by insertion from a previous combination with transmittal 73 ("Environmental Sustainability of AMA National Meetings"). The MSS Caucus voted to re-combine the bolded language with this item, as their asks are more similar to each other than the original asks of transmittal 73.

and private funding for research into the environment 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 and environmental racism as ~~a~~ priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.	
Encouraging increased Accessibility and Utilization of Occupational Pulmonary Lung Disease Screenings RESOLVED, That our AMA amend Policy 365.988 "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by insertion as follows: **Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988** Our AMA ~~supports~~: (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) supports taking a leadership role in assisting state medical societies in implementation of such programs; ~~and~~ (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (6) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings.	
Increasing Diversity in Stem Cell Biobanks and Disease Models RESOLVED, That our AMA encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations; and it be further RESOLVED, Our AMA amends Policy H-460.915, "Cloning and Stem Cell Research," **Cloning and Stem Cell Research, H-460.915** Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) urges the use of stem cell lines from different ethnicities in disease models; ~~(2)~~(3) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); ~~(3)~~(4) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); ~~(4)~~(5) encourages strong public support of federal funding for research involving human pluripotent stem cells; and ~~(5)~~(6) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology; and be it further RESOLVED, That our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

represent the population.	
Opposing Mandated Reporting of LGBTQ+ Status RESOLVED, That our AMA amend Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity" as follows: **Opposing Mandated Reporting of People Who Question Their Gender Identity and Sexual Orientation, H-65.959** Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Waste Receptacles in all Restroom Stalls for Menstrual Product Disposal RESOLVED, That our AMA amend H-65.964 "Access to Basic Human Services for Transgender Individuals" as follows: **Access to Basic Human Services for Transgender Individuals H65.964** Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's 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 one's gender identity, and (3) will advocate for the inclusion of waste receptacles in all restrooms including male designated stalls for safe and discreet disposal of used menstrual products by people who menstruate.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees RESOLVED, That our AMA support the provision of safe, culturally, and religiously sensitive operating room scrubs and hospital attire options for both	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

patients and employees.	
Expanded Housing Voucher Anti-Discrimination Protections RESOLVED, That our AMA support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income; and be it further RESOLVED, That our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Ensuring Fair Opportunities For International Medical Students RESOLVED, That our AMA will encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; and be it further, RESOLVED, That our AMA will amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools” by addition and deletion as follows: **Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968** Our AMA: 1. supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance; 3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~ 4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and 5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. and be it further RESOLVED, That our AMA will advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.	
Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment RESOLVED, That our AMA support that Medicare Part B cover wheelchair ramps and associated home installation for beneficiaries for whom using a wheelchair at home is "medically necessary."	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement RESOLVED, Our AMA advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education; and be it further RESOLVED, Our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants RESOLVED, That our AMA encourages transparency from institutions in the medical school	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

application process for DACA recipients, including, when possible on a national level: (1) the percentage of Deferred Action for Childhood Arrivals applicants of total applicants, (2) the percentage of accepted Deferred Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage of matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants, (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals applicants.	
Ground Ambulance Services and Surprise Billing RESOLVED, That our AMA oppose surprise billing practices for ground ambulance services.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Encouraging Universal Return-To-Play Protocols For Common Sport Injuries In Collegiate And Professional Athletes RESOLVED, That our AMA encourages interested parties to: (a) establish a standard, universal protocol for return-to-play recovery for collegiate and professional athletes; (b) promote additional evidence-based studies on the effectiveness of a universal protocol for evaluation and post-injury management course at collegiate and professional level; (c) support national and state efforts to minimize the consequences of inadequate recovery windows for collegiate and professional athletes.	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA
Increasing Regulation And Labeling Of Fragrances In Personal Care Products, Cosmetics, And Drugs RESOLVED, That our AMA 1) work with relevant stakeholders to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and 2) advocates for increased categorization on the use of a “fragrance free” designation; and be it further RESOLVED, That our AMA supports increased identification of hazardous chemicals in fragrance	**Retain in transmittal queue** – no concrete evidence of significant & relevant activity from the AMA

compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one's body.	
Addressing Medical Misinformation Online RESOLVED, That AMA policy D-440.915 be amended by addition and deletion as follows: **Medical and Public Health Misinformation ~~in the Age of Social Media~~ Online D-440.915** Our AMA: (1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites 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, search engine companies, online retail companies, online healthcare companies, and other entities owning websites 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.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Against Legacy Preferences as a Factor in Medical School Admissions RESOLVED, That our AMA recognizes that legacy	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

admissions are rooted in discriminatory practices; and be it further RESOLVED, That our AMA oppose the use of legacy status as a screening tool for medical school admissions; and be it further RESOLVED, That our AMA study the prevalence and impact of legacy status in medical school admissions.	
Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation RESOLVED, That our AMA support initiatives that decrease financial and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients, regardless of immigration status, excluding medical tourism as defined in the AMA Code of Ethics 1.2.13; and be it further RESOLVED, That the AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status; and be it further RESOLVED, That our AMA amend H-370.982 by addition to read as follows: **Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982** Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, immigration status, perceived obstacles to treatment or follow-up, patient contribution to illness, or past use of resources should not be considered. (2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. (3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions. (4) Patients must be informed by their physicians of	

allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision. (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.	
Additional Interventions to Prevent Human Papillomavirus (HPV) Infection and HPV-Associated Cancers *222 Expansion of Medicaid Coverage of HPV Screening:* RESOLVED, That our AMA amend Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition as follows: **HPV Vaccine and Cervical Cancer Prevention Worldwide H440.872** 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	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**

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. *257 Preventing Human Papillomavirus (HPV) Infection and HPV-Associated Cancers in People Who Are Incarcerated:* RESOLVED, That our AMA amend policy H-55.971, "Screening and Treatment for Breast and Cervical Cancer Risk Reduction", by addition and deletion as follows: **Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971** 1. Our AMA supports programs to screen all ~~women~~ individuals with relevant anatomy for breast and cervical cancer and that government funded programs be available for low income ~~women~~ individuals; the development of public information and educational programs with the goal of informing all ~~women~~ individuals with relevant anatomy 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~~ individuals 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. 3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to in-office primary HPV testing. and be it further RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-sampling in the U.S. to determine whether it can decrease health care disparities in cervical cancer screening.	
Residency Application Support For Students of Low Income Backgrounds RESOLVED, That our AMA advocate for residency application platforms that are no-cost to all residency applicants; and be it further RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services.	**This item will be transmitted by our section to the 2023 Annual Meeting of the AMA House of Delegates (please see Appendix 3).**
Amending Bylaw 7.3.2 to Enable Medical Student Leadership Continuity RESOLVED, That our AMA amend Bylaw 7.3.2 to allow Medical Students to serve on the Medical Student Section Governing Council for up to 200 days after graduation.	**Retain in transmittal queue** – Our MSS Caucus decided against transmitting this resolution until we send our modified and new Internal Operating Procedure document (IOPs)

Appendix 3 - Transmittals being sent to the 2023 Annual Meeting of the House of Delegates

1. 53 Supporting the Use of Gender-Neutral Language
2. 152 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions
3. 73 Environmental Sustainability of AMA National Meetings
4. 94 Hospital Bans on TOLAC
5. 134 Movement Away from Employer-Sponsored Health Insurance
6. 216 New Policies to Respond to the Gun Violence Public Health Crisis
7. 212 Increased Education and Access to Fertility Resources For U.S. Medical Students
8. 99 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation
9. 209 Tribal Public Health Authority
10. 210 Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to Include Medical Professionals as a Party Who Can Petition the Court
11. 82 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
12. 258 Residency Application Support For Students of Low Income Backgrounds
13. 243 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
14. 54 Support for Mental Health Courts
15. 194 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use
16. 211 Purchased and Referred Care Expansion
17. 220 Reconsideration of the Birthday Rule
18. 247 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
19. 139 Drug Policy Reform
20. 250 Ground Ambulance Services and Surprise Billing
21. 125 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
22. 109/245 Supporting Harm Reduction
23. 248 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
24. 222/257 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
25. 236 Studying Population-Based Payment Policy Disparities
26. 221 Indian Health Service Graduate Medical Education
27. 213 Medicaid Managed Care for Indian Healthcare Providers
28. 241 Opposing Mandated Reporting of LGBTQ+ Status
29. 232 The Health Care Related Effects of Recent Changes to the US Mexico Border
30. 202/229 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
31. 227 Billing for Traditional Healing Services
32. 80 Providing Reduced Parking Fees for Patients and Trainees
33. 149 AMA Study of Chemical Castration in Incarceration
34. 111 Increase Employment Services Funding to People with Disabilities
35. 175 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
36. 205 Addressing Inequity in Onsite Wastewater Treatment
37. 240 Increasing Diversity in Stem Cell Biobanks and Disease Models
38. 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud

39. 219 Amending Access to Confidential Health Services for Medica Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
40. 237 School-To-Prison Pipeline
41. 96 Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses
42. 254 Against Legacy Preferences as a Factor in Medical School Admissions
43. 91 Encouraging Collaboration between Physicians and Industry in AI Development
44. 179 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
45. 206 Indian Health Service Licensure Exemptions
46. 218 Tribal Health Program Electronic Health Record Modernization
47. 12 Reducing Costs of CMS Limited Data Sets for Academic Use
48. 190 Recognizing the Burden of Rare Disease
49. 191 Increasing the Availability of Automated External Defibrillators
50. 238 Environmental Health Equity In Federally Subsidized Housing
51. 176 Supporting Intimate Partner and Sexual Violence Safe Leave
52. 249 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
53. 195 Study Integrating Comparative Effectiveness Research into the FDA Approval Process
54. 192 SNAP Expansion for DACA Recipients
55. 231 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
56. 178 Interrupted Patient Sleep
57. 184 Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”
58. 120 Formal Transitional Care Program for Children and Youth with Special Healthcare Needs
59. 253 Addressing Medical Misinformation Online
60. 126 Regulation of Phthalates in Adult Personal Sexual Products
61. 183 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
62. 197 Protecting Workers During Catastrophes
63. 256 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
64. 242 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
65. 226 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-Cost Rape Test Kits

Appendix 4 - Preliminary final aggregate of MSS pending transmittals rankings, by the MSS Caucus, from highest to lowest priority

Rank	Transmittal	Impact	Urgency	Time in queue	Theme	Timeliness
1	73 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings	2.6	2.1	3	3	2.56666667
2	82 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers	2.22222222	2	3	9	2.40740741
3	139 Drug Policy Reform	2.71428571	2.28571429	2	14	2.33333333
4	134 Movement Away from Employer-Sponsored Health Insurance	2.7	2.2	2	2	2.3
5	53 Supporting the Use of Gender-Neutral Language	2.1	1.8	3	6	2.3
6	96 Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses	2.1	1.8	3	28	2.3
7	54 Support for Mental Health Courts	2	1.75	3	9	2.25
8	160 Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid	2.44444444	2.22222222	2	2	2.22222222
9	94 Hospital Bans on TOLAC	1.88888889	1.77777778	3	1	2.22222222
10	109 Support Harm Reduction Efforts through Decriminalization of Possessing of Non-Prescribed Buprenorphine	2.44444444	2.11111111	2	14	2.18518519
11	99 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation	2.14285714	1.28571429	3	7	2.14285714
12	107 Abolishment of the Resolution Committee	2.28571429	2.14285714	2	27	2.14285714
13	216 NEW POLICIES TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS	2.625	2.75	1	5	2.125
14	258 Residency Application Support For Students of Low Income Backgrounds (CME Report A)	2.75	2.625	1	7	2.125
15	237 School-To-Prison Pipeline	2.77777778	2.55555556	1	23	2.11111111
16	80 Providing Reduced Parking Fees for Patients and Trainees	1.8	1.5	3	19	2.1
17	210 AMENDMENT TO AMA POLICY FIREARMS AND HIGH-RISK INDIVIDUALS H-145.972 TO	2.77777778	2.44444444	1	5	2.07407407

	INCLUDE MEDICAL PROFESSIONALS AS A PARTY WHO CAN PETITION THE COURT					
18	12 Reducing Costs of CMS Limited Data Sets for Academic Use	1.75	1.375	3	25	2.04166667
19	149 AMA Study of Chemical Castration in Incarceration	2.11111111	2	2	17	2.03703704
20	130 Establishing Comprehensive Dental Benefits Under State Medicaid Programs	2.3	1.8	2	2	2.03333333
21	152 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions	2.2	1.9	2	11	2.03333333
22	194 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use	2.75	2.25	1	6	2
23	253 ADDRESSING MEDICAL MISINFORMATION ONLINE	2.375	2.625	1	28	2
24	202 Access to Naloxone for Vulnerable and Underserved Populations	2.63636364	2.27272727	1	14	1.96969697
25	209 TRIBAL PUBLIC HEALTH AUTHORITY	2.6	2.3	1	4	1.96666667
26	248 INCREASING ACCESS TO GENDER-AFFIRMING PROCEDURES THROUGH EXPANDED TRAINING AND EQUITABLE REIMBURSEMENT	2.6	2.3	1	8	1.96666667
27	85 TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms	1.6	1.2	3	28	1.93333333
28	91 Encouraging Collaboration between Physicians and Industry in AI Development	1.44444444	1.33333333	3	20	1.92592593
29	218 TRIBAL HEALTH PROGRAM ELECTRONIC HEALTH RECORD MODERNIZATION	2.375	2.375	1	20	1.91666667
30	243 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees	2.44444444	2.22222222	1	4	1.88888889
31	191 Increasing the Availability of Automated External Defibrillators	2.66666667	2	1	20	1.88888889
32	120 Formal Transitional Care Program for Children and Youth with Special Healthcare Needs	1.88888889	1.77777778	2	23	1.88888889
33	211 PURCHASED AND REFERRED CARE EXPANSION	2.375	2.25	1	4	1.875
34	232 THE HEALTH CARE RELATED EFFECTS OF RECENT CHANGES	2.33333333	2.22222222	1	10	1.85185185

	TO THE US MEXICO BORDER					
35	212 INCREASED EDUCATION AND ACCESS TO FERTILITY RESOURCES FOR U.S. MEDICAL STUDENTS	2.4	2.1	1	1	1.83333333
36	111 Increase Employment Services Funding to People with Disabilities	1.875	1.625	2	13	1.83333333
37	192 SNAP Expansion for DACA Recipients	2.25	2.25	1	19	1.83333333
38	241 Opposing Mandated Reporting of LGBTQ+ Status	2.44444444	2	1	8	1.81481481
39	221 INDIAN HEALTH SERVICE GRADUATE MEDICAL EDUCATION	2.28571429	2.14285714	1	7	1.80952381
40	229 NALOXONE ALTERNATIVES OR ADJUNCTS TO COMBAT SYNTHETIC OPIOID-INDUCED RESPIRATORY DEPRESSION	2.28571429	2.14285714	1	14	1.80952381
41	175 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures	2.375	2	1	12	1.79166667
42	126 Regulation of Phthalates in Adult Personal Sexual Products	1.75	1.625	2	20	1.79166667
43	220 RECONSIDERATION OF THE BIRTHDAY RULE	2.22222222	2.11111111	1	2	1.77777778
44	247 SUPPORT FOR MEDICARE EXPANSION TO WHEELCHAIR ACCESSIBILITY HOME MODIFICATIONS AS DURABLE MEDICAL EQUIPMENT	2.3	2	1	2	1.76666667
45	148 The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly	1.8	1.5	2	20	1.76666667
46	176 Supporting Intimate Partner and Sexual Violence Safe Leave	2.57142857	1.71428571	1	15	1.76190476
47	236 Studying Population-Based Payment Policy Disparities	2.33333333	1.88888889	1	4	1.74074074
48	250 GROUND AMBULANCE SERVICES AND SURPRISE BILLING	2.2	2	1	2	1.73333333
49	125 Exclusion of Race and Ethnicity in the First Sentence of Case Reports	1.6	1.6	2	3	1.73333333
50	213 MEDICAID MANAGED CARE FOR INDIAN HEALTH CARE Providers	2	2.125	1	4	1.70833333
51	219 Amending Access to Confidential Health Services for Medica Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents	2.25	1.875	1	9	1.70833333

52	179 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population	2	2.11111111	1	11	1.7037037
53	223 MEDICAID HEARING COVERAGE	2.33333333	1.77777778	1	2	1.7037037
54	151 Evaluating Clinical Outcomes of Mobile Health Technology	1.77777778	1.33333333	2	20	1.7037037
55	174 Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients	2.22222222	1.88888889	1	20	1.7037037
56	197 Protecting Workers During Catastrophes	2.3	1.8	1	16	1.7
57	222 PREVENTING HUMAN PAPILLOMAVIRUS (HPV) INFECTION AND HPV-ASSOCIATED CANCERS IN PEOPLE WHO ARE INCARCERATED	2.2	1.9	1	17	1.7
58	245 ADVOCATING FOR ACCESS TO SAFER SMOKING KITS AS PART OF HARM REDUCTION SERVICES	2.125	1.875	1	14	1.66666667
59	226 AMENDING POLICY H-80.999, “SEXUAL ASSAULT SURVIVORS” TO IMPROVE KNOWLEDGE AND ACCESS TO NO-COST RAPE TEST KITS	2.1	1.9	1	15	1.66666667
60	244 EXPANDED HOUSING VOUCHER ANTI-DISCRIMINATION PROTECTIONS	2.2	1.8	1	19	1.66666667
61	228 SPECIAL DIABETES PROGRAM FOR INDIANS	2.1	1.9	1	19	1.66666667
62	257 EXPANSION OF MEDICAID COVERAGE OF HPV SCREENING (CEQM WIM Report A)	2.11111111	1.88888889	1	1	1.66666667
63	259 Amending Bylaw 7.3.2 to Allow Medical Students to Serve on the MSS Governing Council After Graduation	2.11111111	1.88888889	1	27	1.66666667
64	183 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis	1.88888889	2	1	13	1.62962963
65	184 Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”	2.11111111	1.77777778	1	12	1.62962963
66	254 AGAINST LEGACY PREFERENCES AS A FACTOR IN MEDICAL SCHOOL ADMISSIONS	2	1.875	1	7	1.625
67	206 Indian Health Service Licensure Exemptions	2.25	1.625	1	7	1.625
68	227 BILLING FOR TRADITIONAL	2.1	1.7	1	2	1.6

	HEALING SERVICES					
69	205 Addressing Inequity in Onsite Wastewater Treatment	2.22222222	1.55555556	1	4	1.59259259
70	249 INCREASED INCLUSIVITY AND ADMISSION POLICIES CLARIFICATION FOR DACA MEDICAL SCHOOL AND RESIDENCY APPLICANTS	2	1.77777778	1	7	1.59259259
71	178 Interrupted Patient Sleep	2.11111111	1.66666667	1	7	1.59259259
72	256 LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION (CEQM MIC Report A)	2	1.77777778	1	10	1.59259259
73	204 National Fertility Coverage Mandate	2	1.77777778	1	12	1.59259259
74	235 Emergency Anti-Seizure Interventions	1.88888889	1.88888889	1	20	1.59259259
75	240 INCREASING DIVERSITY IN STEM CELL BIOBANKS AND DISEASE MODELS	2.25	1.5	1	3	1.58333333
76	195 Study Integrating Comparative Effectiveness Research into the FDA Approval Process	2	1.75	1	6	1.58333333
77	242 WASTE RECEPTACLES IN ALL RESTROOM STALL FOR MENSTRUAL PRODUCT DISPOSAL	2.25	1.5	1	8	1.58333333
78	238 Environmental Health Equity In Federally Subsidized Housing	1.88888889	1.77777778	1	16	1.55555556
79	233 CONSERVATORSHIP AND GUARDIANSHIP REFORM	1.85714286	1.71428571	1	15	1.52380952
80	189 Promoting a Fragrance-Free Health Care Environment	2	1.44444444	1	20	1.48148148
81	190 Recognizing the Burden of Rare Disease	1.88888889	1.55555556	1	4	1.48148148
82	231 EXPANDING INCLUSION OF DIVERSE MANNEQUINS USED IN CPR AND AED TRAINING	1.85714286	1.57142857	1	4	1.47619048
83	246 ENSURING FAIR OPPORTUNITIES FOR INTERNATIONAL MEDICAL STUDENTS	2	1.4	1	7	1.46666667
84	251 ENCOURAGING UNIVERSAL RETURN-TO-PLAY PROTOCOLS FOR COMMON SPORT INJURIES IN COLLEGIATE AND PROFESSIONAL ATHLETES	1.8	1.6	1	25	1.46666667
85	239 ENCOURAGING INCREASED ACCESSIBILITY AND UTILIZATION	1.7	1.6	1	16	1.43333333

	OF OCCUPATIONAL PULMONARY LUNG DISEASE SCREENINGS					
86	230 RESEARCH OF PLASTIC USE IN MEDICINE	1.66666667	1.55555556	1	25	1.40740741
87	252 INCREASING REGULATION AND LABELING OF FRAGRANCES IN PERSONAL CARE PRODUCTS, COSMETICS, AND DRUGS	1.77777778	1.44444444	1	25	1.40740741
88	215 SUPPORTING LEGISLATIVE AND REGULATORY EFFORTS AGAINST FERTILITY FRAUD	1.7	1.5	1	1	1.4
89	234 ADVOCATING FOR THE REGULATION OF WASTE PRODUCTS IN INDUSTRIALIZED FARMING	1.66666667	1.44444444	1	16	1.37037037
90	181 Inclusion of Disability in Medical Student Mistreatment Reporting	1.625	1.375	1	7	1.33333333
91	203 Supporting Further Study of Kratom	1.6	1.3	1	20	1.3
92	198 Incorporating Holocaust Education in Medical Schools on International Remembrance Day	1.5	1.25	1	21	1.25
93	207 Support for Research on Plant-Based Meat	1.5	1.125	1	25	1.20833333
94	225 ESTROGEN AS A RISK FACTOR FOR STROKE IN PATIENTS WITH MIGRAINE WITH AURA	1.44444444	1.11111111	1	25	1.18518519

REPORT OF THE MEDICAL STUDENT SECTION
INTERNAL OPERATING PROCEDURE & ELECTION TASK FORCE

IOPETF Report
(A-23)

Introduced by: MSS Internal Operating Procedure & Election Task Force

Subject: Internal Operating Procedures & Election Task Force Report

Referred to: MSS Reference Committee
(Samantha Pavlock & Justin Magrath, Co-Chairs)

American Medical Association Medical Student Section

Internal Operating Procedures – Section 6

6. Elections.

6.1. **Time of Election.** The Chair-Eelect of the Governing Council (GC) and Medical Student Trustee shall be elected by the MSS Assembly at the Interim Meeting. The remaining ~~Governing Council~~ GC members, with the exception of the Immediate Past Chair, shall be elected by the MSS Assembly at the Annual Meeting of the MSS. The ~~Governing Council~~ GC shall set the day and hour of such elections and ~~shall~~ communicate thise ~~day and hour~~ to the medical student members of the AMA ~~at least thirty (30) days~~ prior to each MSS Meeting ~~Interim Meeting and Annual Meeting~~.

6.1.1. Should there not be an Interim/Annual meeting and a Special Meeting is constituted, the Governing Council shall communicate the day and hour of such elections to medical student members.

6.2. **Eligibility.** All members of the MSS are eligible to be elected to any office.~~, except:~~

6.2.1. MSS members who serve ~~or will serve in~~ on an AMA Council or in an AMA Liaison position may not also serve ~~as~~ in a voting ~~Governing Council~~ GC position or as the Medical Student Trustee ~~at the same time for more than two months.The only exception shall be that a MSS member may hold an AMA Council or AMA Liaison position and the position of Immediate Past Chair simultaneously.~~

6.2.2. MSS members who serve on a Region Executive Council, as Regional Delegates or Region Alternate Delegates, or representatives from other organizations to the MSS Assembly (Section 10.3.2-10.3.5), are eligible to run but may not concurrently serve in a voting GC position or as the Medical Student Trustee.

6.3. **Nominations.** Nominations for ~~Governing Council~~ GC positions shall be received in advance of the Annual Meeting (in advance of the Interim Meeting for the Chair elect and Medical Student Trustee), pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the ~~Governing Council~~ GC.

6.4. **Speeches.** Candidates are allowed to address the Assembly for a period of time determined by the Speakers ~~up to a maximum of three minutes~~ during a general Assembly session, as scheduled by the Speakers. ~~In addition, the Chair of the GC, or his or her designee, shall ask each candidate a number of questions on issues of relevance during a general Assembly session, as scheduled by the Speakers. The Speakers will notify candidates of the maximum length of speeches at least one day prior to their speech.~~

6.5. **Campaign Rules.**

6.5.1. **Candidacy**. All MSS members shall be considered potential candidates for all elected offices and shall be bound by all Campaign Rules as stated below during the election cycle for each office, where the election cycle for an office is defined as the time between elections for that office.

6.5.2. **Campaign Period**.

6.5.2.1. Campaigns shall be run only for positions that are electable at the present meeting.

6.5.2.2. Between meetings, campaigns shall be run only for positions that are electable at the upcoming meeting.

6.5.2.3. The official campaign period shall be defined as starting the first day ~~applications~~ the Speakers' Ruling ~~are~~ is made available ~~for~~to MSS members ~~to submit their candidacy~~. The Speakers will notify all MSS members at least fourteen (14) days in advance of the estimated date of release of the Speakers' Ruling.

6.5.2.4. All activities related to announcement of candidacy, endorsement, or campaigning, including but not limited to distribution of materials, communications, and speaking opportunities shall be limited to the campaign period defined above.

6.5.3. **Speakers' Ruling.** A Speakers' Ruling will be issued prior to ~~for~~ each national meeting ~~and~~ with elections, and will contain new rulings, relevant IOP provisions, and how the rules will be enforced. ~~be made available to all potential candidates at the start of the campaign period with a document of rulings so that all candidates have equal access to all rules relating to their campaigns.~~ Once released, the AMA-MSS Speakers reserve the right to issue addendums or announcements ~~during the campaign period~~ as needed, with all changes~~. Any addendums or amendments to the election rules also shall be~~ shared with all candidates. Campaign rules (Section 6.5) are always in effect.

6.5.4. **Candidate Disclosure Form.**

6.5.4.1. The day before the election is scheduled to occur, all candidates nominated, either in advance of the meeting or from the floor at the meeting, shall submit a completed Candidate Disclosure Form to the Speakers~~, the Vice Speaker,~~ or ~~a member of~~ the Rules Committee Chair no later than the time of day designated by the Speakers. No candidate shall be elected if ~~he or she has~~they have no~~r~~t completed and submitted a Candidate Disclosure Form.

6.5.4.2. The Candidate Disclosure Form shall be prepared by the Speakers and shall consist of three (3) parts:

6.5.4.2.1. A portion, completed by the candidate, for disclosure of campaign leadership and campaign finances.

6.5.4.2.2. A portion, completed by the candidate, affirming that the candidate has read the IOP sections relevant to campaigning and the Speakers' Ruling for that election cycle and agrees to abide by the rules and recommendations contained within those documents.

6.5.4.2.3. A portion, completed by the Speakers~~ or Vice Speaker~~, for disclosure of any prior, substantiated infraction(s) of MSS IOPs by the individual declared as a candidate.

6.5.5. **Campaign Materials.** ~~Candidates may distribute only the following campaign materials:~~

6.5.5.1. ~~Buttons, stickers, and pins less than 2.5 inches in greatest dimension.~~ The MSS election manual shall be used to disseminate information about all candidates. The MSS election manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the MSS.

6.5.5.2. ~~Standard-size business cards.~~ Physical campaign materials outside of the campaign forum are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge, and distributed only to members of the designated group.

6.5.5.3. **Curricula vitae and personal statements**.

6.5.5.3.1. Curricula vitae and personal statements of candidates nominated, pursuant to the ~~rules~~Speakers' Ruling of the MSS, ~~in advance~~

~~of the national meeting at which the election will be held~~ shall be included in the online version of the MSS Meeting Handbook.

~~6.5.5.3.2. At the Assembly Meeting, distribution of curricula vitae and personal statements shall be limited to the area and medium/media designated by the Speaker and announced at least 30 days prior to the meeting at which the election will be held.~~

~~6.5.5.3.3. While there will be no limit on the length of curricula vitae, personal statements will be limited to one page (front and back).~~

~~6.5.5.3.4. No trinkets, candy, pens, or other items may be displayed or distributed.~~

6.5.6. The total expenditure per candidate per campaign shall not exceed $~~1,000~~200, including all monetary donations ~~and in-kind donations of goods~~, but not including the candidate's travel to and lodging at the meeting at which the election is held.

6.5.7. **Campaign Communications.**

6.5.7.1. ~~Advance n~~Non-electronic mailings by candidates or other organizations on behalf of a candidate are not permissible.

6.5.7.2. Candidates should be prudent and courteous regarding the number and content of electronic messages, including but not limited to email, social media, phone, text message, and group chats, sent prior to the election.

6.5.7.3. No mode of MSS- or AMA-sponsored communication, including but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning ~~unless otherwise outlined in these IOPs or by the Speakers' Ruling as explained in 6.5.3~~.

6.5.7.4. Candidates using campaign-specific social media accounts can only invite MSS members to follow said accounts, and provide an appropriate disclaimer to this effect, but may not be penalized for any non-MSS members who follow the account.

6.5.8. **Campaigning.** ~~At MSS Regional, state, or school section meetings prior to the meeting at which the election occurs, including attending social events, is prohibited. The candidate's own Medical Student Region, state, or school section meetings are an exception to this rule. Campaigning includes, but is not limited to, discussing candidacy or displaying or distributing campaign paraphernaila.~~

6.5.8.1. Campaigning includes, but is not limited to, discussing candidate platforms or displaying or distributing campaign materials, but does not include merely stating their candidacy for a position.

6.5.8.2. Campaigning at MSS Regional, State, or School section meetings prior to the meeting at which the election occurs is prohibited.

6.5.8.3. Candidate forums where all candidates are given an equal opportunity to speak may commence at the start of the campaign period. Candidates may choose at their discretion to attend, send a representative, or not attend. Any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.

6.5.8.3.1. The Speakers shall coordinate a candidate forum at national meetings.

6.5.9. **Campaign Involvement.**

6.5.9.1. Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role on the GC, in a Region, for a Standing Committee, or other organizational or society representative within or outside of the organization and should explicitly state that they are speaking as an individual unless otherwise outlined in these IOPs or by the Speakers' Ruling ~~as explained in~~ (Section 6.5.3).

~~6.5.9.1.1. Exception: Candidates may wear their own campaign paraphernalia at all times during the Assembly Meeting at which their election is held.~~

6.5.9.2. The campaign involvement of AMA staff members, members of the MSS ~~Governing Council~~ GC, Region Chairs and Acting Chairs, and members of the MSS Rules Committee shall be limited to candidate inquiries regarding election-related matters and AMA-related information so long as that information is made available to all MSS members who request it.

6.5.9.3. Each candidate is allowed the following number and type of public endorsements:

6.5.9.3.1. One ~~(1)~~ optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in; and one ~~(1)~~ optional letter of endorsement by leadership or staff of the state society from the state where the candidate attends medical school are permitted.

6.5.9.3.1.1. These optional letters of endorsement may be included in the MSS Election Manual and may ~~only~~ be ~~publicly~~ displayed ~~at the candidate forum~~ on social media.

6.5.9.3.1.2. During a national meeting, these letters may only be publicly disseminated via the MSS Election Manual and may only be publicly displayed at the candidate forum.

~~6.5.9.3.2. One (1) optional letter of endorsement and a verbal endorsement by the Medical Student Region in which the candidate's medical school is located is permitted by vote within the campaign period.~~

~~6.5.9.3.2.1. The endorsing Region must:~~

~~6.5.9.3.2.1.1. Follow the Region's bylaws regarding issuance of public endorsement.~~

~~6.5.9.3.2.1.1.1. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the AMA-MSS Speakers for guidance.~~

~~6.5.9.3.2.1.2. Document that quorum was met when the voting occurred; and~~

~~6.5.9.3.2.1.3. Document the results of the vote pursuant to Region bylaws.~~

~~6.5.9.3.2.2. The optional letter of endorsement will not be included in the Election Manual but may be displayed on social media.~~

~~6.5.9.3.2.3. During a national meeting, such endorsement may not be publicly disseminated nor displayed except as on social media.~~

6.5.9.3.~~3~~2. An ~~verbal~~ endorsement of a candidate ~~whose medical school is outside the endorsing~~ by a ~~r~~Region is permissible only ~~at the meeting at which the election is taking place~~ within the campaign period.

6.5.9.3.~~3~~2.1. The endorsing Region must:

6.5.9.3.~~3~~2.1.1. Follow the Region's bylaws regarding issuance of public endorsement;

6.5.9.3.~~3~~2.1.1.1. If a Region does not have bylaws specifying quorum or rules dictating official

support, the Region must contact the Speakers for guidance.

6.5.9.3.~~3~~2.1.2. Document that quorum was met when the voting occurred; and

6.5.9.3.~~3~~2.1.3. Document the results of the vote pursuant to Region bylaws.

6.5.9.3.~~3~~2.2. When speaking in official support of a candidate at an MSS Assembly on behalf of a ~~Medical Student~~ MSS Region, Region Chairs and Acting Chairs must be sure that an official vote by the Region took place in accordance with the Region's bylaws ~~for quorum and rules dictating official support and document that vote~~.

6.5.9.3.~~3~~2.3. Regions may not vote to oppose any candidate.

6.5.10. Candidates must be allowed to fully participate in candidate interviews and question and answer sessions during the Assembly Meeting.

~~6.5.11. At the national meeting at which the election is taking place, a group that invites any candidate for a particular office to speak must invite and make a reasonable effort to accommodate all candidates for that office. Candidates may choose at their discretion to attend or not or may send a representative to speak for them, but any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.~~

6.5.11~~2~~. Receptions and/or hospitality shall not be used for promotion of candidates.

6.5.12~~3~~. **Enforcement.**

6.5.12~~3~~.1. Alleged infractions, including but not necessarily limited to violations of the Campaign Rules, should be reported in writing to the ~~AMA MSS~~ Speakers ~~or Vice Speaker~~, or to ~~any member of~~ the MSS Rules Committee Chair.

6.5.12.1.1. Alleged election infractions shall be reported within a period of fourteen (14) days of discovery, up until seven (7) days before the election, so as to limit a delay in reporting prior to an election that would not allow investigators time to thoroughly undertake their responsibilities delineated below:

6.5.12.1.1.1. In the seven (7) days before an election, any alleged infraction occurring prior to the start of the MSS Assembly must be reported in good faith as soon as possible and no later than two (2) hours after the start of the MSS Assembly and shall be

evaluated by the Rules Committee. The only infractions that may be reported after this point are those that occur after the start of the MSS Assembly.

6.5.12.1.1.2. Any alleged infractions reported outside of these limits will be evaluated upon by the Rules Committees for investigation.

6.5.123.2. **Investigators and Investigative Process.** In the event of an alleged infraction, tThe Speakers ~~and Vice Speaker~~ shall be the lead investigators ~~of any alleged infraction in conjunction~~ with support from the Rules Committee as directed. The Speaker or Acting Speaker shall ultimately be responsible for a decision. No person who is a candidate for the same or paired position ~~in the same election~~ as the candidate being investigated ~~for alleged infractions~~ may participate in ~~any part of~~ the investigation ~~of those alleged infractions~~. ~~The candidate is required to participate in the investigation.~~

6.5.123.2.1. In the event where both the Speakers ~~and Vice Speaker~~ are candidates for the election being investigated, the MSS Chair will designate two (2) members of the Rules Committee as investigators to examine the alleged infraction.

6.5.123.2.2. In the event where either the Speaker or Vice Speaker are a candidate for the election being investigated, the MSS Chair will designate one member of the Rules Committee as an investigator to examine the alleged infraction in ~~tandem~~ conjunction with the remaining Speaker ~~or Vice Speaker~~.

6.5.12.2.3. The investigators are required to include the candidate in the investigation.

6.5.123.3. **Rebuttal Process.** Rebuttal occurs during the course of an investigation where the alleged violator is given the opportunity to defend the actions in the alleged infraction.

6.5.12.3.1. Following their investigation, the investigators shall inform the alleged violator, Region Chairs, and Acting Chairs of the infraction in writing, including the results of the investigation of the alleged infraction.

6.5.12.3.2.The alleged violator shall be offered an opportunity to rebut the alleged infraction in writing. Region Chairs and Acting Chairs shall be offered the opportunity to provide comments on the alleged infraction in writing.

6.5.12.3.3. Following rebuttal and comments, the investigators shall determine whether the alleged infraction is substantiated and shall report

their findings in writing to the alleged violator and Region Chairs and Acting Chairs. For all individuals provided with the report, findings of an investigation of an election infraction should be kept confidential.

6.5.12.3.4. Following this, the lead investigator(s) shall report substantiated infractions to the Assembly but shall not make any recommendation to the Assembly.

6.5.12.3.5. Upon each substantiated infraction of the Campaign Rules, the candidate shall be given an official warning letter from the Speakers.

6.5.123.4. ~~Following their investigation and the alleged violator's opportunity to rebut the alleged infraction and prior to balloting, the investigators shall report substantiated infractions to the Assembly but shall not make any recommendations to the Assembly~~. **~~Candidate Disqualification Process.~~** ~~If a candidate exceeds three (3) substantiated infractions, the GC shall convene to determine whether to disqualify the candidate for that election. This meeting will be governed by the following rules:~~

~~6.5.12.4.1. All GC members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this meeting.~~

~~6.5.12.4.2. The investigators shall present all evidence for and against each violation to the GC including the source of the evidence which will allow for GC members to adequately determine the credibility of the allegations.~~

~~6.5.12.4.3. The candidate in question will have the opportunity to defend themselves during this proceeding in conjunction with a co-counsel of their choosing, including the ability to directly respond to each allegation and call their own witnesses as needed.~~

~~6.5.12.4.4. Region Chairs and Acting Chairs shall be offered the opportunity to provide comments on whether the candidate should be disqualified.~~

~~6.5.12.4.5.After all evidence has been presented, the non-investigator members of the GC shall meet in a closed-door session to decide on the disqualification.~~

~~6.5.12.4.6. During the closed-door session, the Trustee, Trustee-Elect, and Chair-Elect/Immediate Past Chair are permitted to attend and speak, but not vote.~~

~~6.5.12.4.7. The GC should only consider disqualifying a candidate if they find that greater than three (3) violations are substantiated beyond a reasonable doubt~~

~~6.5.12.4.8. A two-thirds (⅔) vote of the non-investigator GC members will be required to disqualify the candidate.~~

6.5.12.5. **Appeals Process.** Appeals occur after a determination of whether an infraction is substantiated ~~or after a determination of whether a candidate should be disqualified.~~ Appeals focus on the process of the investigation or determination. Should a candidate feel that due process was not followed in either of these cases and that an appeal is warranted, they must submit this in writing to the Chair of the MSS~~GC~~ within twenty-four (24) hours of being notified of the result. The GC, excluding investigating members (Section 6.5.12.2) and candidates for the election being investigated, shall convene to review the appeal and determine whether the previous decision should be reversed prior to the close of the AMA House of Delegates. ~~The alleged violator, Region Chairs, and Acting Chairs shall be offered the opportunity to provide comments on whether the appeal is justified.~~ Whenever possible, an appeal should be completed~~reviewed~~ prior to the results of the investigation being released to the Assembly.

~~6.5.13.5. Enforcement of a campaign infraction shall follow a systematic approach. Each candidate, upon each substantiated infraction of the Campaign Rules, shall be given an official warning letter from the AMA MSS Speaker. Exceeding three (3) substantiated infractions during a campaign shall render a candidate ineligible for election to any position during that campaign period.~~

6.6. **Voter Eligibility.** Credentialed MSS members acting as MSS Delegates for the meeting will be eligible to vote.

6.7. **Method of Election.**

6.7.1. When there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

6.7.2. All contested elections shall use instant runoff voting without separate runoff elections.

6.7.2.1. The ballot shall give voters the option of ranking candidates in order of preference.

6.7.2.2. If a candidate receives a simple majority of first preferences, that candidate is elected.

6.7.2.3. If no candidate receives a majority of first preferences, an instant runoff retabulation shall be performed. The instant runoff retabulation shall be conducted

in rounds. In each round, each voter's ballot shall count as a single vote for whichever continuing candidate the voter has ranked highest. The candidate with the fewest votes after each round shall be eliminated until only two (2) candidates remain, with the candidate then receiving the greatest number of votes being elected.

6.7.~~2~~3. **Voting Periods.** There shall be one voting period at each meeting for elections. Should Speaker or Section Delegate candidate(s) wish to drop down to Vice and Alternate elections, respectively, an additional voting period may be held. ~~the Interim Meeting for the selection of the Chair Eelect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Section Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. If no Speaker and/or Section Delegate candidates intend to drop down to Vice and Alternate elections respectively, the election(s) will be included in the first voting period. If necessary, Aan additional balloting period will may be held for the elections of the Section Alternate Delegate and/or Vice Speaker.~~

6.7.~~3~~4. ~~First~~ **Ballot.** ~~At the Interim Meeting, one individual~~ Ranked voting ballots (Section 6.7.2) shall be used by ~~the~~ credentialed MSS Delegates. ~~to cast one vote for the Chair Eelect and one vote for the Medical Student Trustee (Section 10.5). At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to cast one for each of the four seven (7) five positions: the Vice Chair, AMA Section Delegate, Section Alternate Delegate, At Large Officer, and Speaker, Vice Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council GC positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.~~

~~6.7.34.1. **Election of Section Alternate Delegate**. If necessary, Aafter the election of the AMA Section Delegate, all unsuccessful candidates who were nominated for the office of AMA Section Delegate may be added to the existing Section Alternate Delegate ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Section Alternate Delegate from the previously declared candidates and among those so nominated. Election to the office of Section Alternate Delegate requires a majority of the legal votes cast.~~

~~6.7.34.2. **Election of Vice Speaker**. If necessary, aAfter the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker may be added to the existing Vice Speaker ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a written ballot for the election of the Vice Speaker from the previously declared candidates and among those so nominated. Election to the office of Vice Speaker requires a majority of the legal votes cast.~~

6.7.4. **Runoff Election.** If no candidate receives a majority of the legal votes cast or there is a tie, a runoff election will be held between the two (or more if necessary because of a tie) candidates receiving the highest number of legal votes cast.

6.7.5. **Processing**. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the ballot boxes will be sequestered in a private location. At this time, the Chair of the Rules Committee will open the ballot boxes and the Rules Committee will then count the ballots and tabulate the results. The Rules Committee will validate the election results by determining that each ballot is official, candidate who has received a majority of the legal votes cast is equal to or less than the number distributed and will then certify the results in writing. He or sheThe Rules Committee Chair will then immediately forward these results to the Assembly's Presiding Officer. Upon receipt of the Rules Committee's election results and verification, the Presiding Officer will announce the results to the Assembly.

6.7.5.1. First Ballot. The credentialed MSS Delegate will receive one initialed ballot from a designated member of the Credentials Committee at the credentials table during the set voting period.

6.7.5.2. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, additional ballot(s) will be distributed by the Credentials Committee at the request of the Assembly's Presiding Officer. The candidate who receives a majority of the legal votes cast in the runoff election will be declared the winner.

6.7.6. **Appeals.** Appeals of the election process and results must be made in writing to the Assembly's Presiding Officer no later than onetwo (2) hours after the official announcement of the final results.

6.7.6.1. Any appeal of the process of ballot(s) distribution will be considered by the Rules Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.

Any appeal of the process of ballot processing, tabulation, and announcement of results, shall be considered by the Credentials Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.

6.7.6.2. No person who is a candidate in the election being appealed may participate in any part of the appeals process.

6.7.6.3. The Assembly's Presiding Officer and the ~~Governing Council~~ GC will consider the appeals report(s) from the Committee(s) dealing with the matter. Final decision on the election results will be the jurisdiction of the ~~Governing Council~~ GC.

6.8. **Endorsements for Diversity, Equity, & Inclusion Officer**. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (~~as defined in MSS IOP~~ Section 10.3.2), and liaisons to identity-based AMA Sections and Advisory Committees (~~as defined in~~ AMA Bylaw 7.0.1).

6.8.1. Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

6.8.2. Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

[End of Section 6]

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON DISABILITY AFFAIRS, WOMEN IN MEDICINE COMMITTEE, AND COMMITTEE ON BIOETHICS AND HUMANITIES

MSS CDA WIM CBH Report A
(A-23)

Introduced by:	MSS Committee on Disability Affairs, Women in Medicine Committee, and Committee on Bioethics and Humanities
Subject:	Condemnation of Non-Therapeutic Sterilization for Contraception of Women with Disabilities without Informed Patient Consent
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 2022 MSS Annual Meeting, MSS Resolution 042 asked the AMA to support legislative bans for guardians to attain non-therapeutic sterilization for disabled patients. Discussions in the VRC expressed concerns about the wording of the resolved clauses stating that it should use first-person language and may be too narrow. The resolution has been referred to the AMA-MSS Committee on Disability Affairs, Women in Medicine, and Committee on Bioethics and Humanities to complete a report for the AMA-MSS A-23 meeting. The resolved statement was as follows:

> RESOLVED, That our AMA advocate for and actively support national legislation that bans guardians from attaining a sterilization deemed non-therapeutic for their disabled patient in their care.

BACKGROUND

Nontherapeutic sterilization includes any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing and which is not either:

(a) A necessary part of the treatment of an existing physical illness or injury, or

(b) Medically indicated as an accompaniment of an operation on the female genitourinary tract.[1]

Throughout the early 1900s, several states implemented legislation regarding forced sterilization. The process of forced sterilization was even deemed to be constitutional under the Supreme Court decision delivered in Buck v. Bell in 1927. Often rooted in eugenics theories, these forced sterilization procedures typically targeted low-income women and women of color, particularly Black and Native American women.[2,3,4] In Relf v. Weinberger (1974), courts prohibited federally funded programs from continuing to perform forced sterilizations on low-income Black women in the South where in some cases, termination of welfare benefits was threatened if sterilization was refused, even if patients or guardians were illiterate and unable to reasonably consent to the procedure.[9] Similar malpractice occurred in LA and was challenged in Madrigal v. Quilligan (1978).[10] Eugenics have also impacted incarcerated and patients in custody as Buck v. Bell gave

states the power to perform forced sterilization procedures on “inmates of institutions supported by the State who shall be found to be afflicted with a hereditary form of insanity or imbecility,” a ruling which has yet to be overturned[5]. From the 1920s to the mid-1970s over 60,000 people in the U.S. were involuntarily sterilized and the 1927 ruling remains intact today.[6] Sterilizations are not limited to disabled patients. Between 1997 and 2014 over 1,000 women, disability unspecified, were forcibly sterilized in California prisons.[7] In Tennessee, there was a program that shortened inmates’ jail sentences by 30 days if they agreed to a birth control implant or vasectomy, which was deemed a violation of the federal constitution in 2017.[8] In 2020, a complaint was filed against Irwin County Detention Center in Georgia, alleging forced sterilizations had been performed on women in Immigration and Customs Enforcement (ICE) custody.[11,12] This indicates the harm that previous laws and rulings continue to have on the legality of forced sterilization, as well as the ways in which eugenics and racism continue to influence the way sterilization is performed today.

When discussing the sterilization of women, there are many ethical considerations at play. The American College of Obstetricians and Gynecologists (ACOG) put forth a committee opinion in 2017 that discusses these ethical principles as they apply to all women (with and without disability). Broadly, they emphasize that the “ethical approach to sterilization must balance promoting access for women who wish to use it as a method of contraception, but safeguard against coercive or unjust uses”. Coercive and unjust uses may include those in which women may not fully understand the permanence or those in which physician recommendations of sterilization may be influenced by race, ethnicity, and socioeconomic status. While not mentioned directly by ACOG, it is possible that disability may also impact physician recommendations of sterilization shown through historical studies of those with disabilities being sterilized involuntarily[24,25]. In light of these ethical challenges, ACOG also highlights that there are many reversible, effective alternatives (such as long-acting reversible contraceptives aka LARCs) to permanent sterilization. In cases where permanent sterilization is considered, ACOG emphasizes the importance of informed consent. Informed consent is providing the patient with sufficient information and ensuring adequate understanding of that information to ensure they are then able to make a decision on their medical treatment[26]. Informed consent can be provided by many patients with disabilities, but providers should ensure that each patient is able to fully understand the medical procedure being discussed since previously there have been instances of individuals not fully understanding what they are agreeing to[13,27]. Extensive counseling should be performed, emphasizing permanence and including information about risks, benefits, and available alternatives. Performing sterilization without informed consent or the patient’s knowledge is unethical and should not be performed. In addition, a physician overriding a patient’s autonomy to “protect” the patient is unethical and should be avoided.. Their recommendations were the following:

- Respect for an individual woman's reproductive autonomy should be the primary concern guiding sterilization provision and policy.[13]
- Coercive or forcible sterilization practices are unethical and should never be performed.[13]
- Obstetrician-gynecologists should provide presterilization counseling that includes a discussion of a woman's reproductive desires and reversible alternatives that are as effective as permanent sterilization.[13]

The United Nations Convention on the Rights of Persons with Disabilities affirms the legal capacity of persons with disabilities and their rights to retain their fertility. They support having access to sexual and reproductive health services which include voluntary

sterilization and any other method of contraception on an equal basis with others and prohibit forced sterilization and forced abortion.[14] Persons with disabilities are very often perceived as asexual or sexually inactive. However, they are sexual beings in the same way as other people, and may also wish to become parents and should not be deprived of their sexual and reproductive rights.[14] According to the World Health Organization, guardians of patients with disabilities may endorse nontherapeutic sterilization to prevent unwanted pregnancy in some cases due to vulnerability to sexual abuse.[14] However, sterilization does not protect against sexual abuse nor relieve the obligation to provide protection from such abuse. Its also not recommended as treatment for menstrual management.

Men with intellectual disabilities may also be subjected to sterilization or treatments to suppress sexual drive.[14] There is a disparity in the permanent effects of sterilization among the sexes as female sterilizations had over 14 deaths per year while male sterilization had 0 deaths but some major complications. [15,16] Although forced sterilizations mainly affect women, there have also been court cases involving sterilization of disabled men. The 1975 case A.L. vs G.R.H. ruled against parents having their intellectually disabled minor son get a vasectomy and Kennedy v. Kennedy (2014) affirm that court approval is necessary before the sterilization of a womans disabled son for which she has conservatorship.[28,29] Although vasectomies are releatively safe, the most common complications are hamartomas and infection.[30]

According to the National Women's Law Center and its report on the forced sterilization of disabled people in the US, two states currently have legislation banning forced sterilization: Alaska and North Carolina. Alaska (13.26.316) states for individuals under guardianship, sterilization procedures cannot be conducted without consent or on behalf unless there is a danger to their physical health. North Carolina (35A-1245) offers specific language on sterilization of an individual with mental illness or intellectual disability stating "guardian of the person shall not consent to the sterilization of a ward with a mental illness or intellectual disability unless an order from the clerk has been obtained in accordance with this section." The law goes further to specify the necessary steps to obtain clerkship approval, which primarily emphasizes medical necessity as a danger to physical health. The report further references 31 states and Washington, DC which allow forced sterilization of disabled persons. Within this subgroup, the laws seem to vary in language describing the exact requirements for a person with mental illness or intellectual disability to have forced sterilization. However, the overarching themes seem to be a court-based approval process, medical proof of mental illness or intellectual disability, evidence of patient consent to the "best of their abilities to inform", and signed documentation from approved guardians. It should be noted 9 of the 31 states allow forced sterilization on the precedent of previous court decisions and have not yet codified these policies into law. The remaining 17 states (and 3 territories) either do not have legislation or court precedent, or state that currently courts cannot make these decisions but could do so in the future.[17-21]

DISCUSSION

Forced non-therapeutic sterilization has historically been an act of discrimination and violation of human rights for disabled patients, affecting both male and female patients, with roots in eugenics and ableism in legislations such as Buck v. Bell that remain intact today. The use of sterilization for disabled women who have not or are unable to provide consent has been utilized as a method of menstrual control and to prevent unwanted

pregnancies in patients who are sexually active or vulnerable to sexual abuse. However, we affirm ACOG's and the WHO's statement that informed consent is of the utmost priority in the appropriate patient care of all populations. We recognize that in cases of severe disability, in which the patient is unable to provide consent for themselves, the responsibility of medical decisions must be carefully considered by the caregivers and medical providers. When informed consent is not possible, it is important to not put the patient at risk of unnecessary harm, such as the surgical interventions involved in sterilizations. Coerced or forced non-therapeutic sterilization is an extreme method of pregnancy prevention when reversible and less invasive methods, such as intrauterine devices, hold the same efficacy. It's unethical to impose medically unnecessary procedures that permanently alter one's body when there are safer options available. In cases where a female patient is intellectually or physically disabled, where they are unable to care for themselves hygienically, it may be difficult for caregivers to support their menstruation. However, sterilization is never the first-line of treatment for this. Amenorrhea can be induced with combined oral contraceptives, transdermal patches, and transvaginal rings. Surgical interventions that cause sterility, such as hysterectomy and endometrial ablation, are only considered if all other modalities have failed.[22] We suggest including "menstrual control and pregnancy prevention" in the language to clarify the uses sterilization has been indicated for. Currently, there are only two states in the U.S. with legislation banning nontherapeutic sterilization and 31 that allow forced sterilization through the court. Therefore, this is an important and timely issue affecting the bodily autonomy of many vulnerable women. We recommend expanding the language of the resolved clause to include "petitioners" along with guardians since in some courts, such as Vermont and Delaware, a third-party petitioner may undergo the process to request sterilization of the patient[23]. We also suggest expanding language to include "vulnerable circumstances," as there have been cases of forced sterilizations in prisons and ICE custody.

CONCLUSION

Nontherapeutic sterilization without the consent of the patient is unethical and violates their bodily autonomy. The medical concerns leading caregivers to seek sterilization of disabled patients such as pregnancy prevention and menstrual concerns are better regulated by less invasive and reversible methods such as LARCs and oral contraceptives. Legislation allowing forced sterilizations have been ableist against the reproduction of disabled patients and eugenic in nature. Currently, only two states prohibit forced non-therapeutic sterilization, although organizations such as ACOG and the WHO recommend that informed consent is necessary and the patient's desires should be centered in their healthcare services. We affirm their stance that coerced sterilization is a violation of human rights, regardless of an individual's disability status.

RECOMMENDATIONS

Your CDA, WIM, and CBH recommend that the following recommendation be adopted as amended by addition and deletion and the remainder of this report is filed:

> RESOLVED, That our AMA advocate for and actively support national legislation that bans guardians or petitioners from attaining a sterilization deemed non-therapeutic (i.e for menstrual control or pregnancy prevention) for ~~their disabled patient~~ patients with disabilities or vulnerable circumstances in their care.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY OF MEDICINE AND COMMITTEE ON LONG RANGE PLANNING

MSS CEQM COLRP Report A
(A-23)

Introduced by:	MSS Committee Name on Economics and Quality in Medicine and MSS Committee on Long Range Planning
Subject:	Expanding and Reclassifying Emergency Medical Services
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

On behalf of CEQM and COLRP, we are submitting this report to highlight our recommendations regarding Resolution 021: Expanding and Reclassifying Emergency Medical Services.

Resolution 21 was initially introduced to our AMA-MSS at the Annual 2022 meeting. We thank the authors for their advocacy and contributions on the pressing issue of supporting and expanding emergency medical services. The original resolution asks three things of our AMA: first, to recognize the impact of emergency medical service (EMS) providers on patient outcomes; second, to support classification of EMS as an essential service; and third, to expand the definition of emergency services to include healthcare services "involving out-of-hospital treatment and transportation." Online and in-person testimony was overall supportive, though it was noted that resolve clause one may be better suited for reaffirmation, and there was feedback including testimony from the American College of Emergency Physicians (ACEP) that resolve clauses two and three would benefit from clarification. The full resolution presented to our AMA-MSS at Annual 2022 is as follows:

> RESOLVED, Our AMA recognizes the impact of health care services provisioned by emergency medical service (EMS) providers on patient health outcomes; and be it further
>
> RESOLVED, Our AMA supports state and federal classification and establishment of EMS as an essential service; and be it further
>
> RESOLVED, That our AMA amend H-130.970 by addition:
>
> > **Access to Emergency Services H-130.970**
> > 1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility or involving out-of-hospital treatment and transportation after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the

implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.

Given this feedback, Resolution 021 was referred for further study regarding the implications of classification of EMS as an essential service and of out-of-hospital treatment and transportation as an emergency service. We will address each of these issues with the goal of presenting a comprehensive review so that our AMA-MSS can make an informed decision on whether or not the AMA should be asked to support reclassifying EMS and amending H-130.970.

BACKGROUND

Emergency Medical Services

Emergency Medical Services (EMS) first started as ambulance transport in 1966 as a part of the Highway Safety Act in response to growing concerns related to injuries sustained in traffic accidents.[1,2] In 1973, the federal EMS Systems Act formally defined EMS as a “system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery in an appropriate geographical area of health care services under emergency conditions.”[3] The act provided over $300 million in funding to develop both state and local EMS systems through public and non-profit private entities, in addition to providing federal guidelines for such systems.[3] However, in 1986 the Consolidated Omnibus Budget Reconciliation Act (COBRA) significantly cut federal funding and provided states with block grants that led to increased variation in EMS structure, function, and funding.[4,5] In an effort to remedy the fragmented oversight of EMS systems, Congress established the Federal Interagency Committee on Emergency Medical Services (FICEMS) in 2005 to oversee the coordination of the federal agencies with jurisdiction over different aspects of EMS.[6] In 2011 there were more than 21,000 EMS agencies nationwide, and in 2014 the collaborative effort “EMS Agenda 2050” was released to set a framework for cohesive EMS systems advancement, with the support of both FICEMS and the National EMS Advisory Council (NEMSAC).[7,8] More recently in 2021, FICEMS released a strategic plan, but the structure and funding of EMS systems still varies significantly across states and localities.[7,9]Currently, EMS entities in the United States operate under various ownership structures including private for-profit, volunteer, combined fire and police, hospital-based, and public agencies. According to the National EMS Information System, about 44% of EMS agencies are nonprofit, 33% are government-operated, and 23% are for-profit, with nonprofit and government-operated agencies more common in rural areas and for-profit agencies more common in urban areas.[10]

EMS agencies generally receive money in two ways: through reimbursements for transportation and through public or private funding sources.[11] Despite far outgrowing its beginnings as ambulance transport, EMS is still reimbursed by public and private payers as only a transportation benefit on a fee-for-service basis.[2] Depending on their certification level, state laws, and local guidelines, EMS personnel today provide a wide range of services including but not limited to automated defibrillation, administration of medications, advanced airway management, electrocardiogram interpretation and cardiac monitoring, and in some cases procedures such as pericardiocentesis or thoracostomy.[2,12]None of these services, however, are reimbursed in the absence of hospital transport. In 2018 almost one third of the 42.6 million EMS responses did not result in a hospital transport, leaving more than 11 million calls uncompensated.[2,13] Reasons for non-transports include,

but are not limited to, adequate care being provided on the scene, management of exacerbations of chronic conditions in those who lack primary care, and EMS being used as a form of social support for those who are isolated.[2,11] A 2014 RAND study reported that the federal government could save as much as $560 million annually by allowing EMS the flexibility to take low-acuity patients to locations other than emergency departments such as hospice and behavioral health facilities.[2,14] Recent pilot projects have been launched to reimburse ambulances for transporting to alternate locations, but this still only covers EMS as transportation providers, which may not account for the cost of EMS readiness and actual services rendered.[15,16]

The cost of EMS readiness, broadly, is the cost of maintaining an EMS system which is adequately trained, equipped, and staffed to handle the needs of the community it serves, not including the actual cost of services rendered. There is, however, no industry standard formula for calculating readiness cost, as it varies greatly by the population and geographic range covered by an agency.[17,18] Rural agencies often lack the call volume to distribute readiness costs, meaning they would need to be reimbursed significantly more per transport just to cover their operating costs.[11] The Bipartisan Budget Act of 2018 has tried to compensate for this by extending add-on payments to the Ambulance Fee Schedule of 2% for urban, 3% for rural and 22.6% for “super-rural” transports, but the program expired in December 2022,[11] and many still argued that reimbursement rates were capped below the actual cost of the ride, let alone covering readiness costs. A 2007 report found that Medicare paid 6% below the average cost of ground ambulance services and others have reported that Medicaid often paid less than half of the cost of ground ambulance services.[13,19] Overall, it has been estimated that 72% of all EMS transports are reimbursed below the actual cost incurred for a call.[13]

In addition to payments, EMS systems receive funding from taxes, federal grants, and charitable contributions.[20]While for-profit agencies are structured to generate revenue for shareholders, often charging higher fees and avoiding low-profit calls, nonprofit, public, and volunteer agencies are reliant on government funding to provide universal access to emergency medical care. In the current structure, rural EMS systems are particularly vulnerable to financial and staffing crises given their often inadequate local tax base and the alarming rate of rural hospital closures.[21–24]The majority of EMS workers in rural areas are actually volunteers.[2,22,25] There have been efforts to increase federal funding for EMS including the Supporting and Improving Rural EMS Needs (SIREN) Act of 2018, which created a grant program for agencies in rural areas, and the recently introduced Supporting Our First Responders Act (SOFRA), which would provide $50 million annually for five years to establish a grant program.[24,26–28]

Essential Services

While an official definition of “essential services” is not universally agreed upon, they generally encompass services that a government is required to provide its citizens.[13,17,29]The origins of essential services are loosely defined in a string of court cases concerning the constitutionality of amendments to the Fair Labor Standards Act (FLSA), ultimately leaving the power to define what constitutes “essential” up to states and local municipalities.[17,30] States typically exercise this authority in the context of who must report to work under adverse conditions, as seen throughout the country during the coronavirus disease of 2019 (COVID-19) pandemic.[13,31,32] While specifics vary by state, examples of essential services include law enforcement, food and agriculture, energy, water and wastewater, transportation, public works and infrastructure support,

communications, government essential functions, and critical manufacturing. Examples of reported essential health services include: healthcare providers and caregivers, hospital and laboratory personnel, workers in other medical and biomedical facilities, manufacturers of goods necessary for medical personnel, necessary pharmacy workers and more.[32] Notably, EMS providers were universally listed as essential workers during the initial COVID-19 pandemic response.[31,33–35]

Theoretically, EMS designation as an essential service opens the door to more taxpayer funding, assures government support, and provides an opportunity to set a minimum standard.[7,17,33] Practically, funding may remain inadequate even in states that formally recognize EMS as an essential service.[29] The National Association of Emergency Medical Technicians (NAEMT) and NEMSAC have each called for the designation of EMS as an essential service, noting that its exclusion from this designation in policy making has contributed to the chronic underfunding of EMS systems.[13,36]Though less than half of states explicitly identify EMS as an essential service, several states recently passed legislation to this effect including Pennsylvania, Iowa, Nevada, West Virginia, Hawaii, Nebraska, Louisiana, and Tennessee.[33,34]

Emergency Services

Emergency services are currently defined by our AMA according to policy H-130.970, which the original resolution seeks to amend, essentially as health care services provided specifically in a hospital emergency facility in response to an emergency medical condition as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA).[5] Notably, the courts have ruled that hospital owned ambulances are considered a de facto extension of the hospital and are therefore under EMTALA mandate, though potentially excluded from this policy.[37,38] Emergency services are implicated in a number of policy and advocacy efforts by our AMA. The aforementioned policy H-130.970,Access to Emergency Services, goes on to state that emergency services should be covered by all payers, that they should be exempt from prior authorization and out-of-network billing, and that their provision is an ethical responsibility. Additionally, policy D-130.989 asks our AMA to “promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy,” and policy D-130.971 asks our AMA to “expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care…”

DISCUSSION

The current structure of EMS entities across the country is fragmented at best, and that the transportation-dependent payment structure of EMS reimbursement in the United States is outdated according to the range of services now provided by EMS personnel. In 2007 the Institute of Medicine (IOM), now the National Academy of Medicine (NAM), recommended that EMS reimbursement be evaluated to include readiness costs and permit payment without transport, yet the current model incentivizes transport to hospitals and leaves out-of-hospital treatment uncompensated.[39] It has been postulated that the burden of uncompensated care provided by EMS may be as high as $2.9 billion.[13] The insufficient reimbursement has left many EMS systems reliant on public and charitable funding, and volunteers to staff their departments, resulting in financial instability and

staffing shortages, particularly in rural areas.[11,21–25,40] Understaffing and broader coverage areas may lead to delays in care, decreased quality, and increased costs.[17,18] Resolution 21 aimed to address some of these inadequacies by asking our AMA to recognize the impact of EMS providers on patient outcomes, support establishment of EMS as an essential service, and expand the definition of emergency services to include healthcare services "involving out-of-hospital treatment and transportation." Given that EMS personnel fall into the category of allied health professionals and our AMA has existing policy D-360.998 recognizing the "important role nurses and other allied health professionals play in providing quality care to patients," your committees felt the first resolved has already been addressed.

Overall, the primary outcome of EMS classification as an essential service seems to be the allocation of government funds to these services. While your committees were not able to identify the exact financial implications of being designated an essential service, it is worth mentioning that several national organizations endorse it including the NAEMT and the NEMSAC, and it has already been done in several states. In states where EMS is recognized as an essential service, the state government provides fundings for these services, lessening the burden on local communities and mitigating the financial strain exacerbating access to EMS in rural areas. Though it is unknown whether this allocation has led to actual improvements in patient care and outcomes, it can be assumed that having adequate funds to provide necessary patient care in the first place is a positive outcome. An excerpt from the American College of Emergency Physicians (ACEP) policy[41] reads:

"Essential to Public Health & Safety": While recognized as a formal subspecialty practice of medicine by the American Board of Medical Specialties, EMS additionally represents an essential component to a community's overall wellbeing in serving the health and medical safety of its citizens. EMS professionals represent indispensable members of a locale's emergency response system and in aggregate, represent an essential aspect of both national health and human services and national homeland security capabilities. EMS is on par with law enforcement and fire suppression services in importance of critical services within a community. All such critical services should be significantly and adequately funded and included in community resiliency planning and operations.

Finally, Resolution 21 asked to expand "emergency services" as defined by existing policy H-130.970 to include healthcare services involving "out-of-hospital treatment and transportation." Out-of-hospital treatment and transportation is an incredibly broad category that could be interpreted to include any care provided in any location, including primary care offices. As written, this language may have a vast array of unintended consequences, for example expanding EMTALA mandates to include primary care providers. Your committees did, however, investigate the implications of expanding emergency services to instead include EMS services specifically. As previously mentioned, three current AMA policies would be affected by the expansion of emergency services to include EMS; H-130.970 states emergency services should be covered by all payers and exempt from prior authorization and out-of-network billing, D-130.989 again asks for all health payers to be required to cover emergency services, and D-130.971 asks our AMA to work with relevant societies to gather data and identify best practices for the staffing, delivery, and financing of emergency services. From a coverage perspective, Medicare and Medicaid cover medically necessary EMS services and though commercial plans can vary, the majority of issues related to coverage of EMS services are due to out-

of-network surprise billing. Notably, our AMA-MSS has already taken steps since this resolution was introduced to address this issue. Transmittal 250 “Ground Ambulance Services and Surprise Billing,” originally introduced during the AMA-MSS Interim 2022 meeting, has been sent to the House of Delegates (HOD) for the Annual 2023 meeting and asks our AMA to oppose surprise billing practices for ground ambulance services. Though “ground ambulance services” is admittedly more narrow than “EMS,” it is worth noting that much deliberation and thought went into the use of this simple language to start with at the current juncture.

Additionally, your committees have concerns that there may be unanticipated effects of expanding emergency services to include EMS, given that it could potentially be extrapolated to expand the scope of EMTALA regulations. While it is certainly the goal of our AMA-MSS to increase access to needed care, it is possible that expansion of EMTALA guidelines to include EMS services may have a paradoxical effect by increasing demand on an already strained system. It is also feasible to imagine that for-profit entities, which currently comprise nearly a quarter of EMS agencies, may pull out of the market if care were to be mandated regardless of ability to pay. EMTALA itself is an unfunded “mandate,” allowable under the pretense that it is technically only a requirement for Medicare eligibility, and extending this to include EMS may have unforeseeable consequences. It should be noted, however, that current AMA policy H-130.970 does explicitly state that the individual remains responsible for payment in instances where no coverage is applicable. Still, the best case scenario would be the exemption of EMS from surprise billing, which is already being transmitted to the HOD, and expansion of public funding for EMS, which your committees feel is better addressed by EMS classification as an essential service.

In drafting this report, your committees spoke to the authors of Resolution 21 to elicit their original intent in expanding the definition of emergency services. The proposed amendment in their third resolved clause was actually written in response to feedback they received regarding their research into surprise billing practices, and was intended to open a dialogue regarding the billing structure of EMS. Your committees certainly appreciate this goal, but remain weary of the potentially wide-reaching implications of redefining “emergency services.” Additionally, while it is well within the scope of our AMA to advocate for improved access, quality, and reimbursement, we acknowledge that there are multiple organizations dedicated to this purpose in the EMS field with whom we should collaborate. Existing AMA policy D-130.971, the Future of Emergency and Trauma Care, addresses this exact issue, though EMS would be presumably excluded given “emergency/trauma services” language is explicitly defined by policy H-130.970 to refer to in-hospital treatment as discussed previously.

CONCLUSION

The purpose of this report is to provide our AMA-MSS with the relevant information to appropriately determine 1) if EMS should be classified as an essential service, and 2) if our AMA should expand its definition of emergency services to include out-of-hospital treatment and transportation. While the precise implications of EMS classification as an essential service remain unclear, EMS is already attributed this status in many ways except in official policy, where it has the potential to remove barriers to chronic underfunding. Given the current financial state of EMS and its integral role in the administration of healthcare throughout the country, including to our most vulnerable

populations, your committees agree that efforts to improve EMS reimbursement and funding align with the goals of our AMA-MSS.

Emergency services as defined by our AMA are currently afforded three main advocacy points: required coverage by all payers, exemption from out-of-network billing, and support for data collection and collaboration with specialty societies to improve staffing, delivery, and financing. Including out-of-hospital treatment and transportation in the definition of emergency services is far too broad an ask. When narrowed to more specifically include EMS as an emergency service, your committees still have significant reservations regarding the potential for unintended consequences, including the inclusion of EMS under EMTALA. However, we do agree with the authors that our AMA-MSS should support exemption from surprise billing and collaboration to improve the effectiveness and efficiency of EMS systems. While surprise billing is already being addressed, your committees did identify that policy D-130.971 regarding the improvement of EMS system delivery and financing would benefit from the explicit inclusion of "EMS."

RECOMMENDATIONS

Your Committee on Economics and Quality of Medicine and Committee on Long Range Planning recommends that the following recommendations are adopted and the remainder of this report is filed:

1) Your committees recommend that "The Growing Nursing Shortage in the United States D-360.998" be reaffirmed in lieu of the following:

   RESOLVED, Our AMA recognizes the impact of health care services provisioned by emergency medical service (EMS) providers on patient health outcomes; and be it further

2) Your committees recommend that the following be adopted:

   RESOLVED, Our AMA supports state and federal classification and establishment of EMS as an essential service; and be it further

3) Your committees recommend amendment to existing policy "The Future of Emergency and Trauma Care D-130.971" in lieu of the proposed third resolved clause:

   The Future of Emergency and Trauma Care D-130.971
   Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services and Emergency Medical Services (EMS) systems, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care;

   (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties;

(3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care;

(4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation;

(5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care;

(6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and

(7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

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RELEVANY AMA AND AMA-MSS POLICY

Coverage of Emergency Services D-130.989
Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition"; (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules.

The Future of Emergency and Trauma Care D-130.971
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage

areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975
Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.

Air Ambulance Regulations and Payments D-130.962
Our AMA will: (1) support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency; (2) work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances; and (3) support stakeholders sharing air ambulance best practices across regions.

The Growing Nursing Shortage in the United States D-360.998
Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;

(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;

(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;

(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;

(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION AND COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CME CGPH Report A
(A-23)

Introduced by:	MSS Committee on Medical Education and MSS Committee on Global and Public Health
Subject:	Advocating for the Inclusion of Weight Bias Training for Medical Students
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 2022 Annual Meeting, MSS Resolution 049 asked the AMA to formally recognize the negative effects of weight bias on patients to address this specifically alongside other forms of bias. In addition, the resolution called for the integration of weight bias training into undergraduate medical education as well as amendment of existing policy H440.821 to demonstrate acknowledgment and inclusion. The following Resolved clauses from Resolution 049 were referred to the Committee on Medical Education:

> RESOLVED, Our AMA recognizes the negative effects of weight bias on patients and physicians and be committed to addressing it alongside other forms of bias; further be it
>
> RESOLVED, Our AMA supports the inclusion of weight bias education for medical students as part of the anti-bias training curricula, while working with relevant stakeholders; further be it
>
> RESOLVED, To support weight-inclusive health policy, our AMA amends Policy H440.821, “Person-First Language for Obesity”
>
> > **Person-First Language for Obesity to Decrease Weight Bias, H-440.821**
> > Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; (3) encourages healthcare providers to use evidence-based interventions when discussing health and disease with patients; and (443) will educate health care providers on the importance of person-first language for treating patients with obesity, including the harmful effects of weight bias and other similar assumptions; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

The primary concern of the resolution was lack of sufficient evidence of improved patient outcomes and long-term changes in medical student perception of patients affected by obesity with weight bias training. In addition, it was proposed that this problem has been addressed through multiple existing policies and is not novel enough to consider for adoption.

MSS Resolution 049 was therefore referred to the AMA-MSS Committee on Medical Education (CME) for report to be completed prior to the AMA-MSS A23 Meeting.

BACKGROUND

Research into the effectiveness of weight bias training has been less extensive compared to other forms of bias training. Nonetheless, multiple studies involving clinical education programs, including those for medical[1], nursing[2], and marriage and family therapy[3], have demonstrated that students who have undergone weight bias training recognized the importance of the training. Additionally, the students who underwent training have an improved understanding of their own personal bias and the importance of treating all patients the same, regardless of any preconceived notions they may have had due to the person's weight. These studies have also shown that when educators conduct prejudices towards obese patients, the students tend to develop those same judgements and the cycle perpetuates. Immediately following completion of the programs, students reported that they became more aware of the cases of practitioners demonstrating inappropriate patient interactions due to their own personal weight bias.

Although some studies have shown that students who undergo weight biased training have an improved understanding of their own bias towards obese patients[,4], there are also other studies that have demonstrated no changes in behavior[1]. Additionally, many of the studies that did show positive effects towards weight-based biases only looked into the short-term impacts of implicit bias training. A common problem that arose in several studies involved students enrolled in healthcare fields that were not medical school. Many studies lacked an understanding about the terms "obese", "BMI", and other terms associated with patients of increased weight and size[3]. This may not be applicable to medical students as much as it is to those other types of students since this is already incorporated into a medical student's education.

There is existing AMA policy regarding implicit bias, including 295.193 MSS Implicit Bias and Its Effects on Healthcare and Its Incorporation into Undergraduate Medical Education, H-65.951 Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions, among others, and policy H-425.972: Healthy Lifestyles, policy H-440.821, and policy H-65.951 as discussed by HCC. While they may not mention weight bias specifically, weight bias may be considered an example of implicit and explicit bias, prejudice, and discrimination.

DISCUSSION

There appears to be a lack of research that includes both the short- and long-term effectiveness of weight bias training. While multiple studies have shown promising results with the short-term effects of weight bias training, there is a lack of medical student-specific research that can be applied broadly to medical students. Additionally, studies show a significant lack of understanding and awareness about medical students' and physicians' implicit and explicit bias toward obese patients[5]. This can be compounded by

the biases of others on the healthcare team that other studies have shown to be significant in impacting the quality of care for obese patients when compared to patients who do not fall into that same category. While there is evidence that weight bias is a problem when treating patients with obesity, the long term effectiveness of strategies to reduce weight bias is still unknown[6]. Additionally, there is an association with worse clinical outcomes that can be attributed to clinical biases toward weight[7], but there is a lack of evidence that weight bias training improves those clinical outcomes.

The asks of the resolution are specific to the use of language regarding patients who struggle with obesity and implications of weight bias training in medical schools. However, it could be considered to be already covered under pre-existing AMA policy that advocates for proper use of terminology and actions when considering bias in the context of patient care. Although no existing policy is as specific to weight bias training as Resolution 049 Advocating for the Inclusion of Weight Bias Training for Medical Students, there are other policies that encompass bias in general. Additionally, amending existing policy H-440.821 would impact the current curriculum of undergraduate medical education. This would be difficult without sufficient evidence of the short and long-term benefits of weight biased training, especially with the lack of studies applied specifically to medical students.

CONCLUSION

It is widely recognized that healthcare outcomes in patients affected by obesity are negatively impacted by weight bias within the healthcare system. Resolution 049 was eager to address this and institute positive change for these patients through implementation of weight bias training in the curriculum of medical education. However, this resolution was referred to study due to lack of significant evidence showing long-term benefits of weight bias training in patient outcomes. Our independent research only reiterated the fact that evidence of long-term benefits was lacking. Without significant evidence of positive change, it is unlikely that structural changes to medical education curriculum can be reasonably implemented. Additionally, it is reasonable to believe that existing AMA policy covers the asks of this resolution in terms of advocating for proper use of terminology and recognizing bias in the context of patient care.

RECOMMENDATIONS

Your Committee on Medical Education recommends that the proposed recommendations be not adopted and the remainder of the report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LEGISLATION AND ADVOCACY AND COMMITTEE ON LGBTQ AFFAIRS

MSS COLA LGBTQ Report A
(A-23)

Introduced by:	MSS Committee on Legislation and Advocacy and MSS Committee on LGBTQ+ Affairs
Subject:	Pharmacy Access to Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) & Post-Exposure Prophylaxis (PEP)
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

This report was initiated in response to AMA-MSS Res. 034 “Pharmacy Access to Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) & Post-Exposure Prophylaxis (PEP)”. This resolution was submitted for consideration at the 2022 AMA Annual Meeting (A-22). Feedback on the Virtual Reference Committee (VRC) was mixed, with some citing concerns over scope of practice. The MSS Reference Committee recommended the report not be adopted given concerns over scope of practice. This item was extracted for further discussion at A-22. The verbal testimonies were also mixed. During discussion, a motion was made to refer to study. This motion passed and a report on the matter was assigned to the AMA-MSS Committee on LGBTQ+ Affairs and the AMA-MSS Committee on Legislation and Advocacy. The following resolved clauses of Resolution 34 were referred for report:

> RESOLVED, That our AMA support federal and state efforts to make HIV PrEP prescribable by pharmacists with evidence of a recent negative HIV test in accordance with best practice guidelines, including efforts to make rapid HIV tests available and affordable to patients requesting PrEP; and be it further
>
> RESOLVED, That our AMA support federal and state efforts to make HIV Post-Exposure Prophylaxis (PEP) prescribable by pharmacists.

BACKGROUND

Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) are prophylactic antiretroviral treatments intended to prevent acquisition of Human Immunodeficiency Virus (HIV) in high-risk populations.

PrEP involves daily oral dosing of tenofovir with emtricitabine. Numerous studies have demonstrated the safety and efficacy of PrEP in preventing HIV transmission to high-risk populations. The Centers for Disease Control and Prevention (CDC) recommends PrEP

for people who are HIV negative and have had anal or vaginal sex in the past six months and either: 1) have a sexual partner with HIV 2) have not consistently used a condom and/or 3) have been diagnosed with an STD in the past six months. The CDC also recommends PrEP for people who are HIV negative who use injection drugs and either: 1) have an injection partner with HIV and/or 2) share needles, syringes, or other equipment to inject drugs.

PEP guidelines differ for non-occupational (nPEP) and occupational exposure (oPEP). nPEP should be administered within 72 hours of exposure and includes a 3-drug antiretroviral regimen to be taken for 28 days. No clinical trials have been conducted to determine nPEP's efficacy, however case studies as well as animal model studies have demonstrated its safety and efficacy, per updated CDC guidelines.[1] The CDC recommends PEP for people who are HIV negative (or do not know their HIV status) and in the past 72 hours either: 1) may have been exposed to HIV during sex 2) shared needles or other equipment to inject drugs 3) been sexually assaulted and/or 4) may have been exposed to HIV at work.

As of October 2022, approximately 1.2 million individuals in the United States have HIV. In 2019, 34,800 new HIV infections occurred, which is an 8% decrease in incidence from rates in 2015.[2] HIV disproportionately affects certain populations, particularly men who have sex with men and ethnic minorities, with Black and Hispanic populations being the most highly affected.[3]

Current prescribing patterns are not meeting the needs of the population who could benefit from PrEP. In fact, less than 25% of individuals in which PrEP is indicated are taking the medication.[4] The problem is even more acute in disadvantaged populations, including Black Americans, Latinx identified individuals, rural residents in the South, serodiscordant couples, and Black and Latinx gay, bisexual and other men who have sex with men (GBM). These populations use PrEP at relatively lower rates, yet face a greater risk of HIV contraction. There is a regional dimension to the problem, as well. 52 percent of HIV diagnoses are made in Southern states, while only 27 percent of PrEP users are located in the South.[5]

Although relatively safe, both PrEP and PEP are associated with side effects and risks which necessitate patient monitoring. According to the California Department of Public Health, people on PrEP should receive the following every three months: 1) adherence and risk reduction counseling 2) HIV testing, preferably 4th generation antigen/antibody 3) serum creatinine measurement due to risk of decreased eGFR 4) STD screening and 5) pregnancy testing when appropriate.[6] According to the New York State Department of Health, people on PEP should receive measurement of serum liver enzymes, serum BUN, serum creatinine, and a CBC two and four weeks after initiating PEP, as well as HIV testing four and twelve weeks after initiating PEP.[7]

Many states including California (2019), Colorado (2020), Oregon (2021), Nevada (2021), and Missouri (2021) have implemented a variety of laws allowing pharmacists to prescribe and dispense PrEP and PEP, HIV infection prevention drugs, contingent on either clinical criteria consistent with federal guidelines or adequate testing to confirm negative HIV results.[8-12] Each of these states additionally allow for in house ordering, administration, and interpretation of tests required for initial prescription and continued management of the prescription as well as appropriate reimbursement for consultation and education

about drug therapy, disease prevention, and disease management. Prior authorization of PrEP and PEP is allowed in Nevada, prohibited in California and Colorado, and no clear prior authorization is outlined in Oregon or Missouri.

A majority of the existing literature on this topic focuses on regional or national data with few studies focusing on qualitative and quantitative measures of success including health outcomes, implementation/usage rates, or attitudes in specific states or pharmacies where the laws have already been implemented. One review included six case studies including pharmacies in states with access laws and pharmacist run clinics with integration of other professional clinical oversight. Each served urban areas with diverse populations including Albuquerque, NM; Omaha, NE; Jackson, MI; San Francisco, CA; Kansas City, MO; and Seattle, WA. Most had 50-200 clients (although Seattle saw 695) and ⅝ had some level of physician oversight or collaborative practice agreement.[13] Access was improved for clients, with 74-96% of clients starting PrEP or filling prescriptions on the same day or within a week of evaluation. Moreover, client race varied by setting from 83% White to 77% Black and 47% Hispanic/Latino, and insurance was able to cover the drug in 35-80% patients across the six sites. For the clinics that measured followup, 43% of clients in Jackson, MI were retained by the time of a 6-week testing mandate, and 75% were retained in Seattle, WA with a mean duration of 302 days of continued PrEP usage. Lastly, two sites reported on HIV seroconversions, with one reporting 0 seroconversions and another reporting none among active clients but 1 among those lost to follow-up (who returned for PrEP and tested positive upon evaluation).

This review and others also summarized patient and pharmacist experiences in clinics with and without PrEP/PEP pharmacy access. Overall, 50-95% of individuals said that they supported such laws and expressed a willingness to or comfortability with discussing prescription of PrEP or PEP with a pharmacist, with many citing increased accessibility (of time and location) as a main driver. The major concerns from the patient perspective included privacy and confidentiality, confusion about cost coverage, pharmacist training, or a preference for prescriptions from physicians over pharmacists. In contrast, the major concerns from physicians included concerns about the infrastructure changes, workflow, and resource management to meet an increased burden of services and an increase in training and education to provide adequate consultation services.[13,14]

DISCUSSION

The major argument for pharmacists to prescribe PrEP and PEP is that it would increase accessibility to medications, patient education on medications, improve PrEP and PEP utilization in underserved communities, reduce potential travel and physician associated costs and time, and help curtail the HIV pandemic.[4] The ability for pharmacists to prescribe PrEP and PEP would also promote health equity, as Black and Hispanic patients at-risk for HIV are prescribed PrEP at much lower rates compared to their White counterparts. While patients mostly support the move to have PrEP and PEP prescribable by pharmacists, there is limited data clearly demonstrating a link between pharmacist-led prescriptions and increased PrEP utilization in at-risk populations.[15]

PrEP and PEP are currently underutilized despite their overwhelming effectiveness.[16] This is partially due to under-utilization by physicians. Only 4% of individuals who are eligible for PrEP are receiving PrEP. Additionally, an estimated 1 out of 5 physicians have ever prescribed PrEP. This is mainly due to concerns regarding purview paradox, patient financial constraints, risk compensation, and concern for ART resistance. While these

concerns can be addressed through increased medical education on HIV risk-assessment and indications for PrEP and PEP, pharmacist ability to prescribe PrEP and PEP could help fill this critical gap in medical care.[17]

On the other hand, there are several concerns over granting pharmacy access to PrEP and PEP. Arguably the most substantial concern at this time is the potential impact on patient safety due to education gaps on sexual health risk assessments and PrEP/PEP guidelines associated with bypassing physician prescribing and monitoring. If a patient prescribed PrEP acquires HIV which is not detected due to lack of routine monitoring, that patient is at risk of developing an HIV infection which is resistant to treatment. Additionally, routine monitoring serves to detect changes in kidney function which may occur due to the risk of decreased eGFR associated with PrEP and PEP. Addressing this concern would require additional comprehensive training on PrEP and PEP eligibility and monitoring for pharmacists, as well as a means for pharmacists to order and obtain results for relevant tests. Another concern involves the ever-present issue of scope creep which the AMA has made a priority to combat. The management of PrEP and PEP by a pharmacist would add additional avenues to receiving care other than physician care, and thus will likely not be viewed favorably by the AMA.[18]

There is also the question of pharmacist compensation for these services, since pharmacy staff performance has not historically been evaluated by point of care testing services.[19] Additionally, while several states, such as Washington, permit pharmacists to legally bill Medicaid for services provided in the state, this practice is not universally allowed across states.[20]

In addition to purported benefits and concerns, there is also an issue of feasibility to consider. There is some evidence demonstrating that pharmacy-access PrEP and PEP is a feasible service delivery model[13]. In several states, many of the pharmacy PrEP and PEP programs exist and successfully operate due to a Collaborative Practice Agreement (CPA) or Collaborative Drug Therapy Agreement, in which providers collaborate extensively with pharmacists.[4,21] However, such partnerships may be a challenge to implement, especially if pharmacies have insufficient private space for counseling, resource constraints for training and educating pharmacy staff, and lack a streamlined referral network, especially for medical questions or issues that may be better addressed in a primary care setting. The prescribing protocols and pharmacist collaborative practice laws of each state also differ in their requirements for providing care.[22,23] Pharmacists are already subject to limitations on their ability to perform laboratory testing in 19 states. If pharmacies were granted the ability to prescribe PrEP and PEP, established guidelines or minimum care standards would likely need to be developed with multidisciplinary input. While pharmacy and retail staff often refer those with a preliminary reactive HIV test result to a provider or patient navigator to obtain confirmatory testing, there are many instances where they do not have access to or are uninformed regarding the patient's final testing status or adherence to treatment.[24,25] Insufficient knowledge of the patient's continuum of care can be detrimental when it comes to managing PrEP and PEP delivery. Furthermore, there is concern that some pharmacists may be less familiar with barriers involved in linking patients to care.[26] In these cases, appropriate systems must be put in place to ensure seamless two-way communication and follow-up by the pharmacy once linkage of care is established.

Finally, there is limited evidence regarding the effectiveness and adaptability of PrEP and PEP distribution by pharmacies in lower-income or rural settings, as many programs

studied were implemented in the U.S. within urban regions. This is especially important to keep in mind when incorporating a system that provides referrals to primary care providers where shortages already exist.

Weighing the challenges and benefits associated with pharmacist prescription of PrEP and PEP,
your Committee on Legislation and Advocacy and Committee on LGBTQ+ Affairs noted that many states with successful pharmacy PrEP and PEP prescribing programs operate through CPAs. The establishment of CPAs addresses the challenges of scope creep and coordination of physician follow-up.

Seven states have already introduced bills on pharmacist prescriptions of PrEP and PEP in their respective house chambers and senate floors. As these states continue to debate the nuances of pharmacy access to PrEP and PEP, they will look to the expertise of professional associations like the American Medical Association. Therefore, it is important for our AMA to have policy on this topic that supports increased access to life-saving prophylaxis in a way that promotes pharmacy and physician collaboration.

RECOMMENDATIONS

Your Committee on Legislation and Advocacy and Committee on LGBTQ+ Affairs recommend that the following recommendation be adopted as amended by addition and deletion and the remainder of the report be filed:

> RESOLVED, That our AMA support federal and state efforts to make HIV Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) prescribable by pharmacists through the establishment of Collaborative Practice Agreements with physicians. ~~with evidence of a recent negative HIV test in accordance with best practice guidelines, including efforts to make rapid HIV tests available and affordable to patients requesting PrEP; and be it further~~
>
> ~~RESOLVED, That our AMA support federal and state efforts to make HIV Post-Exposure Prophylaxis (PEP) prescribable by pharmacists.~~

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LEGISLATION AND ADVOCACY AND MINORITY ISSUES COMMITTEE

MSS COLA MIC Report A
(A-23)

Introduced by:	MSS Committee on Legislation and Advocacy and MSS Minority Issues Committee
Subject:	IMG Exemptions from Immigration Caps on IMG-Specific Immigration categories for Green Cards and VISAs
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the June 2021 AMA-MSS Interim Meeting, the AMA-MSS referred Resolution 049 "IMG Exemptions from Immigration Caps on IMG-Specific Immigration categories for Green Cards and VISAs" for study. The final report, COLA MIC Report A was submitted for consideration at the June 2022 AMA-MSS Annual Meeting:

> RESOLVED, Our AMA-MSS support the implementation of a healthcare worker VISA category specifically for IMGs and IMSs, which could ease post-VISA foreign residence requirements and allow for appropriate VISA travel guidelines to continue patient care; and be it further
>
> RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG specific bridge programs between education-based and employment-based VISAs to increase retention of J-1 VISA recipients who complete medical training in the US; and be it further
>
> RESOLVED, Our AMA-MSS support the implementation of profession-specific or education level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H-1B temporary work VISAs in order to decrease barriers of non-citizen International Medical Graduates from practicing in the US.

Testimony on the report was mixed. The International Medical Graduate (IMG) section raised concerns with the recommendations and stated that they are not consistent with current immigration law and may not be feasible. The MSS Reference Committee recommended this report not be adopted given the concerns raised by the IMG section. The report was extracted at the meeting for further discussion. Ultimately, the AMA-MSS re-referred this report for study in order to allow further communication with the IMG section.

BACKGROUND

International medical graduates (IMGs) make up a notable portion of the United States

healthcare workforce and account for 25% of attending physicians and 23% of residents.[1,2] There are various routes for an IMG to obtain permission to work within the United States,
with J-1 and H-1B Visitors International Stay Admission (VISAs) being two of the most popular options.

To apply for a J-1 VISA, various requirements must be met. The applicant must have passing scores for USMLE Step 1 and 2 CK (or equivalent), a certificate from the Educational Commission for Foreign Medical Graduates, an official offer letter for a position in an approved Graduate Medical Education (GME) program, and a letter from the health ministry of the last country in which the graduate held permanent residency stating the need for the occupation. According to the Fellowship and Residency Electronic Interactive Database (FREIDA), the available residency programs to J-1 VISA holders is 4,057 out of over 12,000 residency programs.[3]

The J-1 VISA is education-sponsored and only lasts a maximum of 7 years depending on the program. Typically, the duration of the VISA is limited to the amount of time required to complete the training program. Following the completion of residency, IMGs are expected to return to the country of their last permanent residence to practice for a minimum of 2 years before they are eligible to modify their VISA to return to the United States.

However, under the Conrad 30 waiver, IMGs with a J-1 VISA are eligible for exemption of the 2 year requirement to return to their home residence if IMGs commit to practice in a federally designated Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population for at least three years.[4] The eligibility criteria include: persecution in the country of last legal permanent residence, the 2 year requirement would place hardship on the physician's dependents who are permanent residents or US citizens, and sponsorship by an US governmental agency. The Conrad 30 waiver program additionally needs to be reauthorized every two years by Congress and only gives states 30 waivers, regardless of their size or need. After securing a Conrad 30 waiver, a new VISA is required for employment, such as an H-1B VISA or another immigrant VISA. Recently, The Conrad State 30 and Physician Access Reauthorization Act was reintroduced in Congress. This policy would expand the number of available waivers, enhance employment protection, and extend reauthorization to 3 years. Furthermore, participants, who complete 5 total years of service in an underserved community or Veterans Affairs (VA) facility, will receive priority consideration and exemption from the per-country green card cap, facilitating immigration of IMGs who had traditionally been precluded from such opportunities. The AMA is currently advocating for this bill's passage.[5]

The H-1B VISA is an employer sponsored VISA that is often preferred by IMGs given that it has no 2-year residence requirement in their respective home country. The H-1B's specialty occupation worker category allows foreign-born nationals to enter and stay in the United States for an initial period of 3 years with the scope of renewal for up to 6 years in total, which makes it a highly desirable option for IMGs pursuing further education. Additionally, the spouse and any unmarried children are eligible to seek admission into the country as dependents of the H-1B VISA holder under H-4 category. However, significant caps exist in this VISA category with a current annual limit of 65,000 VISAs each fiscal year.[6] Following H-1B, VISA holders are eligible to apply for employer based greencards, which have a cap of 114,000 per year, out of which only 35,000 can be given to IMGs.

There are some other less commonly issued VISAs for IMGs practicing in the United States. One of them is the O-1 VISA, which is issued to individuals with “extraordinary ability or achievement” in the fields of arts, sciences, business, athletics, or education and is more difficult to obtain early on during training.[7] Another option is the NAFTA (TN) VISA which requires Canadian or Mexican citizenship and allows temporary entry into the United States to work at a professional level.[8] These are generally non-traditional, infrequently pursued paths of entry for IMGs.

IMGs make up 25% of the nation’s physicians workforce and contribute in ways superseding sheer numbers. IMGs tend to choose specialties that are not chosen frequently by the U.S. medical graduates, and contribute to filling crucial gaps in the healthcare workforce.[9,10] One of the significant barriers to current IMGs seeking employment in the U.S. is VISA limitations, especially regarding duration of stay.

International Medical Students (IMSs) attending US medical schools experience similar challenges during their training. The main VISA issued to IMSs is the F1 (Academic Student) VISA which is for those enrolled as full-time students at an accredited academic institution in the United States.[11] Criteria for F-1 VISA eligibility include full-time enrollment, school approval by the Student and Exchange Visitors Program, Immigration & Customs Enforcement, proficiency in English or enrollment in courses leading to English proficiency, sufficient funds for sustained self-support, and intention to maintain residence abroad indefinitely.

Despite graduating from US medical schools, IMSs continue to face challenges similar to those of IMGs due to their need for a VISA. If pursuing H-1B status, IMSs must also search for hospitals that sponsor H-1B and are cap-exempt, meaning sponsorship petitions do not need to occur through the lottery. Cap-exempt hospitals allow IMSs to potentially secure visa sponsorship without the uncertainty of a lottery. Seeking out hospitals that meet these criteria severely limits the options for residency applications. Additionally, most hospitals do not sponsor H-1B status due to the increased liability in addition to administrative and financial burden. For these reasons, many sponsor J-1 status instead of H-1B status.[12]

DISCUSSION

Data exposing the negative impacts on communities suffering from health disparities both globally and within the USA are abundant. Such barriers to medicine are exacerbated in rural communities, likely due to geographic and monetary hardships. As such, these conditions have allowed for the creation of critical access hospitals (CAHs). CAHs operate as federal Medicare categories that receive cost-based reimbursement from Medicare in an effort to provide adequate health care to rural populations. Thus, maintaining the workforce of such facilities is crucial to the lives of millions. Currently IMGs make up 25% of the CAH physician workforce with higher rates in more impoverished communities, CAHs that report recruitment problems, and CAHs with small medical staff.[13] IMGs therefore serve as a valuable function in the US healthcare system, especially when it comes to staffing CAHs and current AMA policy aligns with recruitment of IMGs for this aid in underserved communities. The AMA is currently advocating for solutions to expand the J-1 VISA Waiver Program, in-line with current policies such as Resolution D-255.985, to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage.

The current pandemic shines light on the burden that IMGs and IMSs have to endure in regards to the bureaucratic VISA process. For one, renewal of the F1 VISAs for students requires students to travel back to their native countries for an in-person interview. With the majority of students not working, this can be a financial burden. Additionally, the travel bans placed between countries added significant stress to many students on any type of VISA, as it was unclear how to maintain VISA status due to the inability to re-enter the US. Current AMA policy aligns with the relief of VISA complications. Under Policy D-255.991, our AMA will work with the Educational Commission for Foreign Medical Graduates to minimize delays in the VISA process for International Medical Graduates applying for VISAs to enter the US for postgraduate medical training and/or medical practice.

The H-1B VISA is usually the VISA of choice if the goal is to obtain long term employment as a physician in the United States. However, even when IMGs are approved for the VISA, some training programs last longer than the six years that are covered. Additionally, there is an annual limit on the number of H-1B VISAs issued, and a program that is not exempt from the annual limit may be unable to secure a VISA in a timely manner.[14] For the 2023 application, 127,600 out of 483,927 applications were selected for H-1B VISA registration.[15] Only universities, nonprofit research institutions, and nonprofit organizations tend to be exempt from the annual limit.

In addition to scarcity of H-1B VISAs, current immigration requirements limit where IMGs can work, despite additional opportunities or needs at other locations. For example, once and IMG obtains a VISA, it is tied to their location of employment listed on the application, and it is impossible to work elsewhere. This has caused problems in the COVID-19 pandemic when certain areas of the country are much harder hit and can require a sudden need for physicians. Though willing, IMGs legally cannot help address these transient shortages.[16]

Additionally, after completing residency, obtaining alternative employment after a J-1 waiver is granted is very difficult. Initially, the U.S. State Department will adjudicate a waiver once. Subsequently, only the U.S. Citizenship and Immigration Services (USCIS) has the authority to approve a change of employers. An IMG must file an H-1B change-of-status application that includes evidence that the physician will serve the balance of his or her three-year commitment in an underserved area and that there are exceptional circumstances justifying the change (e.g. a serious breach of contract by the employer, the shutdown of a facility, or something of similar magnitude).[14]

A large reason underlying the decision by the MSS Reference Committee to refer the original resolution for study was whether or not this policy should be internal or external. Upon discussion within our MSS Committee on Legislation and Advocacy and our MSS Minority Issues Committee, we came to the conclusion that this report should be internal to the MSS in its scope. This issue most directly affects IMGs and thus would be much more appropriate and well-received if this topic was brought to the house from the International Medical Graduates Section.

Given the IMG section's comments on the previous report, we have decided to broaden the language of our previous recommendations. We believe it is important to have policy supporting the ability for IMGs to maintain long-term practice in the United States. By broadening our language, our AMA-MSS can support initiatives by the IMG section or another body that aim to decrease barriers facing international medical graduates.

RECOMMENDATIONS

Your Committee on Legislation and Advocacy and Minority Issues Committee recommend that the following recommendation be adopted as amended by addition and deletion and the remainder of the report be filed:

RESOLVED, Our AMA-MSS support measures that ease ~~the implementation of a healthcare worker VISA category specifically for IMGs and IMSs, which could ease~~ post-VISA foreign residence requirements and allow for appropriate VISA travel guidelines to continue patient care; and be it further

RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG specific bridge programs between education-based and employment-based VISAs to increase the capability for ~~retention of~~ J-1 VISA recipients who complete medical training in the US to continue practicing in the US; and be it further

RESOLVED, Our AMA-MSS support the implementation of profession-specific or education level exemptions for residents and physicians ~~from the annual caps for EB-1,2 green cards and H-1B temporary work VISAs~~ in order to decrease barriers ~~of~~ preventing non-citizen International Medical Graduates from practicing in the US.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON LGBTQ AFFAIRS, WOMEN IN MEDICINE COMMITTEE, AND
COMMITTEE ON MEDICAL EDUCATION

MSS LGBTQ WIM CME Report A
(A-23)

Introduced by:	MSS Committee on LGBTQ Affairs, MSS Women in Medicine Committee, and MSS Committee on Medical Education
Subject:	Accuracy and Awareness for Sex Representation in Medical Textbooks
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 2022 MSS Annual meeting, the AMA-MSS referred Resolution 022 which stated:

> RESOLVED, Our AMA supports increased female sex, intersex, and transgender representation in medical textbooks including anatomical images in sex specific and nonspecific content; and be it further
>
> RESOLVED, Our AMA recognizes the need for accurate depictions of female sex anatomy including the clitoris and vulva length, morphology, nerves, and vasculature, and variations in medical textbooks.

VRC comments were mixed. Some identified the entire resolution as reaffirmation while some only identified Resolved Clause 2 as reaffirmation and recommended removal of the resolved clause entirely. Additionally, some VRC comments proposed amendments to the resolved clauses to align with the spirit of the resolution, which is equitable representation. Amendments proposed adopting more inclusive language that represents diverse normal and abnormal human anatomy, not just female sex specific anatomy. Overall, the VRC comments were in support of the resolution, but with amendments to address either reaffirmation or the language.

At the A-22 MSS assembly, the resolution was referred to the AMA-MSS Committee on LGBTQ Affairs, Committee on Women in Medicine, and Committee on Medical Education for a report to be completed prior to the AMA-MSS A-23 meeting. As a joint report, our committees address the concerns raised at the AMA-MSS A-22 meeting regarding the breadth of sex representation needed in medical education.

BACKGROUND

I. Sexual & Gender Diversity Terminology

It is important to establish a shared understanding of terminology for describing sexual and gender diverse populations within this report in order to effectively communicate and avoid misunderstandings that could potentially harm individuals who identify with different gender identities. In this section, we will provide a brief overview of gender diversity

terminology from the AMA Center for Health Equity and AAMC Center for Health Justice's Guide to Language, Narrative, and Concepts1 to ensure that all AMA members have a solid foundation of the following terms used in this report.

Sex: a concept used to describe a person's sex assigned at birth, typically based on a subjective evaluation of external anatomic structure(s) and its comparison to various sex categories.
Gender: conventionally, refers to the social, psychological, and emotional traits, attitudes, norms, and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither. How gender is embodied and defined varies from culture to culture and from person to person.
Gender Identity: how people conceptualize themselves as gendered beings, including one's innate and personal experience of gender. This may or may not align with one's gender expression or biological sex.
Gender Dysphoria: psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.
Cisgender: gender identity in which a person's experiences of their gender matches the gender and sex they were assigned at birth.
Gender Fluid: term to describe individuals whose gender identity is not fixed, but may change over space, time, context, etc.
Gender Nonbinary: an adjective describing a person who does not identify exclusively or at all as a man or a woman; can also be used as an umbrella term encompassing any gender outside of a man or a woman, including but not limited to agender, bigender, polygender, genderqueer, or gender fluid.
Gender Nonconforming: people who do not follow conventional ideas or stereotypes about gender roles.
Intersex: a subset of individuals whose reproductive organs and anatomy (e.g. primary sex characteristics, hormones, chromosomes, etc.) do not align with medically defined and socially expected notions of male and female. Related terms "variations in sex characteristics", "differences of sexual development" or "disorders of sexual development" may sometimes also be used, especially in medical and medical education settings.
Transgender: denotes a person whose sense of personal identity and gender expression does not correspond with their assigned sex at birth.
Gender Inclusive: places, spaces, policies, language, procedures, etc. that validate, accommodate, and honor the existence, experience, and rights of all gender identities and expressions.
Gender Affirmation: the process of matching an individual's gender identity more closely with their outward appearance. This can include changing clothes, names, pronouns, or legal documents to fit their gender identity. It may also include health care needs such as hormones, medical treatments, or surgeries.

II. Demographics

Per the 2020 US census, 50.5% of people reported identifying as female.2 Data from the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System in the US shows that 0.6% of people aged 13 years or old identify as transgender.3 Of these respondents, 38.5% are transgender women, 35.9% are transgender men, and 25.6% are gender nonconforming. Population studies evaluating prevalence of intersex traits is limited because individuals with intersex traits may not self-identify as intersex, and studies may define intersex differently. For example, the National Academies of Sciences, Engineering, and Medicine Committee on Understanding the

Well-Being of Sexual and Gender Diverse Populations reports: “1 in 2,000-4,500 people are born with external genitals that lie somewhere between binary male or female genitalia, but as many as 17 in 1,000 people are born with any variation in their physical reproductive or sexual characteristics.”4

III. Current Medical Education

Medical school curricula, texts, and other educational resources lack representation of variations in sex characteristics, accurate clitoral and vulvar anatomy, and anatomical changes of sex anatomy following surgeries, such as gender affirming care and genital mutilation/cutting.5,6 Dichotomous depictions of sex anatomy are the predominant mode of representation despite binary sex being inaccurate and ignorant of the sexual diversity seen in humans.7 Accurate depictions of clitoral and vulvar anatomy are not present in most recommended anatomic texts as seen in a review of 78 popular medical texts from the 18th to 21st century.5 For example, textbooks frequently misrepresent average clitoral size and presentation of the labia minora by showing inaccurately diminished proportions. Average measurements of clitoral structures were only reported in 2 texts, which conflicted one another; one text reported an average clitoral length of 2.0 cm and the other text stated clitoral length varies from 3.0-4.0 cm, and that MRI and cadaveric surveys report average clitoral length over 4.0 cm.8 Additionally, neither anatomical changes in sex anatomy nor clinical considerations for post-operative individuals (e.g. after gender affirmation surgery or genital mutilation/cutting) are included in medical texts or explicitly taught within medical curricula.9

IV. Health Disparities and Barriers to Care for LGBTQ+ Individuals

There is compelling research demonstrating health disparities among the LGBTQ+ community, including negative experiences with healthcare providers, which is a barrier to these patients receiving optimal care. A report published in 2021 by the Kaiser Family Foundation looking at the health and healthcare experiences of people who identify as LGBTQ+ found that LGBTQ+ people had higher rates of negative experiences accessing healthcare compared to non-LGBTQ+ people.10 Specifically, 21% of LGBTQ+ people reported that they had a healthcare provider make assumptions about them without asking (compared to 11% non-LGBTQ+). In addition, 29% of LGBTQ+ people reported that they had a healthcare provider dismiss their concerns (compared to 16% non-LGBTQ+).

Transgender and Intersex individuals are particularly affected. A 2017 survey of LGBTQ+ adults in the US found that 22% of transgender adults reported avoiding health care due to anticipated discrimination.11 Further, the National Center for Transgender Equality’s report of the 2015 U.S. Transgender Survey that 33% of respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender.12 The survey also reported that although more than three quarters of transgender individuals sought hormone therapy, only half of patients were able to access treatment. In a report published in 2015 by the Human Rights Watch, multiple interviewees who identified as intersex described avoiding or delaying seeking medical care due to past negative experiences with healthcare providers.13 One interviewee specifically identified the reactions from medical providers or trainees in response to examining their genitalia as adverse and stigmatizing events. Barriers to care for transgender and intersex patients appear to be partially driven by widespread lack of

training for providers in sexual and gender diverse population health resulting in individuals struggling to find culturally and clinically competent health care providers.4 As demonstrated by these studies, the pattern of negative healthcare experiences for people who identify as LGBTQ+, particularly transgender and intersex individuals, leads to avoidance of medical care which contributes to dangerous health outcomes. In order to address these disparities, we must fully educate medical students on how to appropriately and compassionately care for sexual and gender diverse patients. An important component of this is ensuring medical education resources represent the variability in sex characteristics as well as the gender diverse appearance and anatomy of genitalia.

There are multiple levels of intersecting factors that influence the well-being of sexual and gender diverse individuals that drive health disparities. According to the 2015 U.S. Transgender Survey, one in four transgender people had problems in the previous year with insurance related to being transgender, including denied coverage for care related to medically transitioning.12 The unemployment rate is three times higher for transgender people in the U.S., and the poverty rate is 29%, compared to 12% of the overall population.12 It is thus unsurprising that these health disparities translated to 33% of transgender people not seeing a doctor in the previous year due to the cost of medical expenses.12 Transgender people were also three times more likely to have to travel more than 50 miles for gender-affirming care than for routine care.12 Lastly, transgender patients present with many comorbidities compared to the larger U.S. population; transgender individuals are five times more likely to have HIV, three times more likely to have a substance use disorder, and eleven times more likely to have attempted suicide.12 Reducing stigma and managing behavioral and environmental risk factors that impact sexual and gender diverse individuals are a few areas where physicians and trainees can intervene in addressing health disparities. Access to proper education in the needs of these patient populations will help physicians and trainees make lasting improvements in health disparities.

V. Lack of inclusive medical school curricula harms transgender patients

Lack of sexual and gender diverse-inclusive medical school curricula in all stages of medical education contributes to the dearth of knowledge among healthcare providers about the transgender community. Transgender patients who do not feel that their providers have enough knowledge about their needs, are less likely to come out and be transparent with providers about the organs they have that may need screening, and as a result have much lower rates of necessary screenings.4 The most recent US Transgender Survey (2015) showed that even among doctors that provide gender affirming care, a quarter of patients perceived that their provider knew only “some” to “almost nothing” about gender-affirming care.12 Nearly a third of transgender people are not out to any of their healthcare providers.12 Only 27% of transgender people with a uterus reported they had a Pap smear in 2014 compared to 2015, contrasted with 43% of the U.S. population.12

VI. Lack of vulvar and clitoral diversity in medical school curricula impacts clinical decision making

Without knowledge of the natural diversity of clitoral and vulvar anatomy practitioners can be influenced to recommend unnecessary cosmetic surgeries to patients.5 Low public knowledge of normal vulvar and clitoral diversity has led to an increase in genital dissatisfaction and subsequently increased demand for cosmetic labiaplasty.7,14 The majority of patients seek labiaplasty due to feelings of genital insecurity with fewer surgeries being performed due to true labial hypertrophy.14 Available evidence suggests

most people seeking labiaplasty have labia minora which fall within the normal range of size variation.14 Currently the American College of Obstetrics and Gynecology (ACOG) recommends practitioners provide ample reassurance prior to cosmetic genital surgery but the lack of vulvar and clitoral diversity taught in medical schools can influence practioner's concept of normal vulvar clitoral anatomy.7,14 Physician concepts of normal labia size vary considerably with surgeons' definitions of desired labial size post labiaplasty varying between 1cm to 4cm.14 The current subjective classification of normal vulvar and clitoral anatomy can lead to misattribution of pelvic floor disorder symptoms as manifestations of labial hypertrophy.14 Unnecessary labiaplasty can worsen symptoms of pelvic floor disorders by increasing pelvic floor overactivity, delaying healing of wounds, and compounding distress related to the vulvar region.14 The lack of a clear definition of labial hypertrophy reflects the absence of normal vulvar clitoral and clitoral variation in medical curricula.

DISCUSSION

Medical learning resources misrepresent the natural diversity shown in vulvar and clitoral anatomy.[5] The lack of understanding of natural variation causes subjective classification of hypertrophy of genital structures and subsequent referral for unnecessary cosmetic surgery.[5,7,14] Providers are encouraged to educate patients seeking cosmetic genital surgery of the natural variation of genital anatomy prior to surgery. Frequently patients who receive counseling will move to defer unnecessary surgery.[14] With a lack of natural vulvar clitoral variation in medical curricula it is difficult for providers to objectively counsel patients on normal variation leading to a gap in quality of care.[5] Increasing representation of variation of vulvar and clitoral anatomy in medical learning resources would provide medical learners and those referring to medical texts with a better understanding of natural variation in anatomical structures leading to better care for patients.

According to a 2015 survey of 4,262 undergraduate medical students from 170 allopathic and osteopathic medical schools across the United States and Canada, 67.3% of the respondents rated, on a 5-point Likert Scale, their LGBTQ+-related curriculum as "fair," "poor," or "very poor".[15] Importantly, expanded medical education interventions encompassing the spectrum and diversity of LGBTQ+ health helped 62.6% of the medical student respondents feel "more prepared" and 46.3% feel "more comfortable" caring for LGBTQ+ patients.[15] These data are supported by a 2018 survey of over 1,000 medical, dental, and nursing students at a top-tier private university in the United States which found that fewer than 50% of students agreed that their formal training had prepared them to treat LGBTQ+ patients.[16] However, it has also been reported that self-reported specific knowledge of transgender and intersex health lags behind knowledge of broader LGBTQ+ health topics in general. However, these deficits in transgender- and intersex-specific knowledge may be addressed through targeted educational interventions.[17] The lack of education in transgender care in undergraduate medical education has been described to continue among providers across all levels, including residents, primary care providers, and specialists.[16-19] A 2018 review identified gaps in transgender medical education as a significant barrier to care for transgender persons.[18] There is a need for a sufficient number of providers proficient in transgender care, and long-term focused transgender-specific curricula that are specialty-specific.[18]

Currently, transgender medical education is largely composed of one-time, attitude- and awareness-based interventions that show significant short-term improvements, but suffer methodologically and longitudinally to ensure trainees' overall competency, preparedness, and comfort pertaining to LGBTQ+ health and care delivery. Consensus in the existing literature supports educational efforts to shift toward pedagogical interventions that are longitudinally-integrated and clinical skills based. Specifically, a 2018 scoping review concluded that strategies to address and positively advance medical education outcomes on transgender health topics should include: (1) specifically naming transgender health as a required topic of curriculum, unique from the larger LGBTQ+ health umbrella, (2) implementing pedagogical interventions that improve attitudes toward and awareness of transgender health inequities and the underlying socio-legal barriers that construct these inequities, and (3) focusing on developing sound clinical skills, emphasizing direct patient–learner interactions.[19] A 2020 study aiming to quantify how much patient interaction and curricula is needed to improve outcomes found that medical students who cared for 35 or more LGBTQ+ patients and received at least 35 LGBTQ+ focused instructional hours, including 10 hours of required curricular education and 25 hours of supplemental education, had significantly higher overall preparedness and knowledge.[20]

A 2020 update on the 2018 scoping review found that notable limitations to the development of curricular interventions on transgender health include paucity of objective educational intervention outcome measurements, absence of long-term follow-up data, and varied nature of intervention types.[21] Moreover, despite interventions around transgender health being progressively recognized as a priority to alleviate health inequities faced by transgender individuals, further implementation and analyses are needed to reach consensus around key elements and evidence-based pedagogical interventions for transgender medical education.[21]

Finally, for medical students and trainees who identify as LGBTQ+, significant anti-LGBTQ+ discrimination and heterosexism have been reported, primarily originating from medical student peers.[22] According to a 2017 survey study at the University of Ottawa, 41.7% of respondents reported anti-LGBTQ+ jokes, rumors, and/or bullying by fellow medical students and/or other members of the healthcare team, indicating a suboptimal learning environment for LGBTQ+ students.[22]

CONCLUSION

Our committees recognize the need for inclusive and accurate anatomical training in order for physicians to best serve their patients. Studies have demonstrated that current medical textbooks focus on male sex anatomy with a lesser proportion of images focused on female sex anatomy, and the representation of surface anatomy of people receiving gender affirming care or post-gender affirming care is not discussed.[5,9] Furthermore, studies have demonstrated that medical textbooks reporting average clitoral size and presentation of the labia minora provide conflicting information and fail to convey the diversity that exists in anatomic structures.[8] Such lack of representation leads to biased clinical decisions. The inclusion of normal genital variation in medical curricula is a potential tool to decrease personal bias in patient management.[5,14]

Proper education on the diversity of genital anatomy in patients is one aspect of a larger need in medical education which is to provide training, knowledge, and skills to medical students to provide the best care for patients identifying as transgender, LGBTQ+, or people with variations in sex characteristics. A study that surveyed people with variations in sex characteristics recounted an experience of an interviewee in which their medical provider or trainee had a negative reaction when they saw their genitalia.[14] A study on medical, dental, and nursing students found that less than 50% of students agreed that their formal training had prepared them to provide quality care to LGBTQ+ patients.[16] This is a need that medical education should address.

RECOMMENDATIONS

The Committee on LGBTQ Affairs, Committee on Women in Medicine, and Committee on Medical Education recommend that the following is adopted as amended by addition and deletion and the remainder of this report be filed.

RESOLVED, Our AMA supports increased ~~female sex, intersex, and transgender representation in~~ representation of variation in genital anatomy within medical ~~textbooks~~ education resources, including but not limited to anatomic~~al~~ images showing variations in sex characteristics as well as genital diversity across the spectrum of gender affirming care~~sex specific and nonspecific content~~; and be it further

RESOLVED, Our AMA ~~recognizes the need for an accurate depictions of female sex~~ supports increased representation and accuracy of vulvar and clitoral anatomy in medical education resources, including, but not limited to, depictions of variation in length, morphology, and neuro-vasculature of the clitoris and vulva ~~length, morphology, nerves, and vasculature, and variations in medical textbooks~~ , as well as an increase in number of clitoral and vulvar anatomic images; and be it further

RESOLVED, Our AMA supports increased representation of gender diverse individuals and people with variation in sex characteristics in the full spectrum of medical education materials, including but not limited to case-based discussions, clinical skills sessions, and board-style questions.

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REPORT OF THE MEDICAL STUDENT SECTION
MINORITY ISSUES COMMITTEE AND
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS MIC CEQM Report A
(A-23)

Introduced by:	MSS Minority Issues Committee and Committee on Economics and Quality in Medicine
Subject:	Immigration Status in Medicaid & CHIP
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the November 2021 AMA-MSS Interim meeting, MSS Resolution 021 asked the AMA to advocate for removing citizenship status as eligibility criteria for Medicaid and CHIP for children. Testimony was initially mixed, with Region 2 and the Committee on Economics and Quality in Medicine (CEQM) opposed to the resolution as written, while the MSS Counselor to the AMA Council on Medical Service, the Minority Issues Committee (MIC), and the MSS Section Delegates supported reaffirmation of existing policy in lieu of this resolution.

The N-21 Reference Committee recommended that H-350.975, D-440.927, H-290.982, and 350.023MSS be reaffirmed in lieu of the following resolve clauses for Resolution 021:

RESOLVED, That our AMA acknowledge the existing disparity in health insurance among Latinx children; and be it further

RESOLVED, That our AMA amend policy H-350.957, Addressing Immigrant Health Disparities:

Addressing Immigrant Health Disparities, H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and supports legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees, and publicizes the legality of accessing these resources.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally

appropriate way upon presentation for asylum regardless of country of origin; and be it further

RESOLVED, That our AMA recognize the importance of culturally- and linguistically-sensitive measures in improving and expanding access to health care insurance by supporting the use of lay community health workers (promotores de salud) in at-risk Latinx communities

However, the N-21 Reference Committee believed that there were novel aspects to the following resolved clause and referred it for study:

RESOLVED, That our AMA advocates for the removal of eligibility criteria based on citizenship status from Medicaid and CHIP.

The resultant report was submitted at A-22 as MIC Report A, “Addressing Health Insurance Coverage Disparity Among Latinx Children." The report attempted to provide an overview of the inequities in health insurance between Latino and non-Latino children in the US. While they found significant coverage disparities that were impacted by eligibility based on immigration status, the authors ultimately recommended reaffirmation of existing AMA Policy H-165.823, “Options to Maximize Coverage Under the AMA Proposal for Reform,” in lieu of adopting a new recommendation. Specifically, the authors appeared to note that clause 4(c) of H-165.823, which states “Our AMA…supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status,” covered the asks of the original resolution. However, the A-22 Reference Committee disagreed with this conclusion, as ACA Marketplace coverage is distinct from Medicaid and CHIP, typically covering a different income bracket of the population, using different sources of funds, and resulting in different levels of affordability for recipients. The A-22 Reference Committee ultimately recommended adoption of the report as amended, but the item was extracted for debate on the MSS Assembly floor. MIC, as the original authors of the report, changed their original position after noting the distinctions between Marketplace and Medicaid/CHIP coverage and supported the Reference Committee amendment. After a lengthy debate, followed by a reconsideration and second debate, the report was ultimately re-referred to MIC with the addition of CEQM for further investigation regarding the inequities in adult Latino coverage (as the recommendation would affect adults as well, and the report’s focus was on children), as well as state finance mechanisms used to cover undocumented immigrants and comparisons to uncompensated care.
In this report, your MIC and CEQM expand upon the work demonstrated in the previous draft to provide an overview of the inequities in health coverage experienced by Latino adults and children and state finance mechanisms that cover low-income immigrants ineligible for Medicaid and CHIP, concluding with a discussion of our MSS’ previous advocacy on this topic and our final recommendation.

BACKGROUND

Non-citizens include people on visas, green cards, those with protected status and those granted deferred deportation, such as DACA. Irrespective of race, higher proportions of noncitizens (25%) were uninsured than citizens (8%)[1,2]. Additionally, Latino and Black noncitizens were least likely to be insured. When looking at the nonelderly population,

noncitizens were significantly more likely to not have a usual source of care, delay care due to cost, and report no doctor's visit within the past year[1,2]. Currently, federal and state policies limit access to comprehensive, affordable healthcare for people born outside of the United States[1,2]. In 2020, the U.S. Census Bureau reported that 4.3 million children under the age of 19 did not have health coverage at any point during the year[3]. Currently, insurance options for immigrant children include Medicaid, Children's Health Insurance Program (CHIP), and private insurance through their parent's employment, if applicable. However, in some states, Medicaid/CHIP eligibility requires five years of legal residency before immigrants can qualify for benefits. Eligibility for government health insurance such as Medicaid or CHIP varies depending on the state of a child's residence. This system is further complicated when accounting for the immigration status of a child and their family. These complications lead to inequities in health insurance access for children throughout the United States. Currently, the number of states that have adopted a policy that allows lawfully-residing immigrant children and pregnant women to be eligible for state-funded Medicaid or CHIP even if they do not meet that residency requirement are 35 and 26, respectively[4]. Outside of these regions, immigrant children without adequate documentation lack access to any form of federal health insurance programs. However, as of September 2021, there are six states and Washington D.C. that offer state funded Medicaid-CHIP equivalent or comparable programs for immigrant children. Currently, states are either offering Medicaid equivalent programs or creating premium or cost sharing subsidies for coverage through the Health Insurance Marketplace, a website where various health care plans available under the Affordable Care Act can be purchased.

Many children have received temporary protected documentation status through the Deferred Actions for Childhood Arrivals (DACA) policy through former president Barack Obama's executive order. This program allows eligible individuals to lawfully work and receive certain benefits such as health insurance. DACA, however, is not a blanket solution for immigrant families, seeing as the stringent requirements for DACA may only cover some family members while leaving others out. This may result in the formation of "mixed-status" families, whereby some family members may have health insurance whereas others do not. Being part of a mixed-status family has been correlated with elevated stress levels and deterioration of mental health due to potential deportation of non-protected family members and difficulty accessing healthcare for the whole mixed-status family[5].

To further complicate situations of children with DACA status, DACA is a program contingent on renewals by presidential actions through Executive Orders. Initially, this expansion of health care access showed a reduction in coverage disparities brought on by immigration status, albeit indirectly. Researchers believe that creation and continuation of these programs is a "positive signal" that makes undocumented individuals seek and utilize healthcare services available to them[6]. Conversely, policies such as the Public Charge Rule have decreased involvement in public assistance programs[7]. The Public Charge Rule proposed a limitation on an individual's permanent residency application if they used any safety-net services such as SNAP or WIC[7]. Even though this proposed rule was eventually dismissed, it is important to note that child access to and use of safety-net programs saw a reduction around the same time that this rule was announced, a phenomenon commonly referred to as the "chilling effect"[7, 8].

A systematic review found that Medicaid expansion was associated with increases in coverage, service use, quality of care, and Medicaid spending, and generally was not

found to be associated with negative consequences such as increased wait times for appointments[9].
In Medicaid expansion states, it was found that low-income adults were 13.9% more likely to have insurance, 5.6% more likely to have a usual source of care, and 5.0% less likely to delay care due to cost post-expansion versus in non-expansion states. Insurance gains were 6.4% lower for Hispanic adults than White adults in expansion states post-expansion; otherwise, gains were similar by race/ethnicity[10].

DISCUSSION

Literature has shown evidence that expanding access to Medicaid/CHIP improves health outcomes. As the AMA, with our goal of improving the general health outcomes for those in the US, there is precedent in advocating for removal of eligibility criteria based on citizenship status from Medicaid and CHIP.

There is some previous AMA policy that is in support of the expansion of citizenship requirements for CHIP/Medicaid. For example, there is the 2021 policy, "Support of Health Care to Legal Immigrants H-290.983" that implies through its emphasis on supporting care for *legal* immigrants, that eligibility should be expanded to non-citizens who have legally immigrated to the US. The policy supports expansion of CHIP/Medicaid healthcare to children granted citizenship through the DACA program, as these children would be legal citizens. However, this AMA policy makes no overt comment about expansion of healthcare to non-citizens, but implies that there should not be expansion of insurance to non-legal citizens. Therefore, in alignment with previous AMA policy, the legality of immigration to the US may influence the political will of AMA to support CHIP/Medicaid expansion of healthcare for immigrants.

Nonetheless, several other recent AMA policies indicate that improving immigrant health is an important priority of the AMA:

(1) "Addressing Immigrant Health Disparities H-350.957" (2019);
(2) "Improving Healthcare of Hispanic Populations in the United States H-350.975" (2020);
(3) "Medicaid and State Children's Health Insurance Program: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982" (2022);
(4) "Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927" (2018);
(5) "Options to Maximize Coverage under the AMA Proposal for Reform H-165.823" (2022).

These AMA policies make clear that it is important to find insurance solutions that improve insurance access for immigrant populations, including those of Latino descent, including non-legal citizens. In particular, H-350.957 ("Addressing Immigrant Health Disparities") explicitly mentions "prevention and treatment of *immigrant children, regardless of legal status*". D-440.927 ("Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services") denounces *public charge* policies and names "[acts] that would deter *immigrants and/or their dependents*". Finally, H-165.823 ("Options to Maximize Coverage under the AMA Proposal for Reform") supports "extending eligibility to purchase Affordable Care Act (ACA) *marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients*, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee

immigration status; and (d) recognizes the potential for state and local initiatives to *provide coverage to immigrants without regard to immigration status*."

Expansion of CHIP/Medicaid insurance is likely one important policy intervention that could be used to improve health outcomes, and such expansion might reasonably include expansion of insurance to non-citizens. This would be particularly beneficial for immigrants lawfully residing in the United States, such as those with Temporary Protected Status, who are not eligible for Medicaid or CHIP coverage. Indeed, these findings suggest that Resolution 021 clause 4 ("That our AMA advocates for the removal of eligibility criteria based on citizenship status from Medicaid and CHIP") is a natural extension of precedent policy.

Some may further argue that expanding CHIP/Medicaid to include non-citizen persons may be a financial burden on citizens of the United States. However, a 2013 report by the Institute on Taxation and Economic Policy (ITEP) estimated that roughly 50% of undocumented immigrant households filed income tax returns using Individual Tax Identification Numbers (ITINs). Additionally, many more who did not file income tax returns still paid taxes via paycheck deduction. In total, ITEP had estimated that undocumented immigrants paid $11.6 billion in state and local taxes, of which $7 billion was in sales taxes, $1.1 billion in income taxes, and $3.6 billion in property taxes[11]. Of course, the numerical values of these tax payments will have drastically varied since the creation of the report, but the underlying sentiment of 'wasting' tax money on those not paying any is incorrect.

CONCLUSION

This report, written upon re-referral of the November 2021 AMA-MSS Interim Meeting MIC Report A "Addressing Health Insurance Coverage Disparity Among Latinx Children", holds the prior findings that immigrant children are negatively and disproportionately affected by health insurance barriers, with citizenship status being a key determinant of coverage and related outcomes. Critically, state-level Medicaid expansions have been shown to increase coverage, reduce unmet care needs, and improve health outcomes for low-income adults. In order to bring these gains to immigrant patients and families at comparable levels to those in white individuals, we determine that removing citizenship status as an eligibility criteria would be an effective policy approach.

Our committee finds that current AMA policy supporting ACA coverage for *undocumented immigrants*, *DACA recipients*, and *immigrant children regardless of legal status*, underscores the relevance and novelty of Resolution 021, including the 4th resolved clause, which asks to remove eligibility criteria based on citizenship status for Medicaid and CHIP. Given the AMA-MSS's role and history of advocacy for the Latino patient population, this would be an appropriate proposal coming out of our Assembly.

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommends that the following Resolved clauses be adopted in lieu and the remainder of this report be filed:

> RESOLVED, That our AMA advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP.

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RELEVANT AMA AND AMA-MSS POLICY

Report of the Council on Medical Service Covering the Remaining Uninsured, N-21 HOD

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 123-J-21, and that the remainder of the report be filed:
1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility–make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
3. That our AMA support extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations.
6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:
a. Our AMA supports modifying the eligibility criteria for premium credits and cost- sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA’s “family glitch,” thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage with respect to the cost of family-based or employee-only coverage and household income. ...
7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion.
8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding.
9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children’s Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet.
10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency

requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
11. That our AMA reaffirm Policy H-165.824, which supports:
(1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits;
(2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income;
(3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections;
(4) eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL);
(5) increasing the generosity of premium tax credits;
(6) expanding eligibility for cost-sharing reductions; and
(7) increasing the size of cost-sharing reductions.
12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities.
13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.
14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report.
15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits.

Improving Healthcare of Hispanic Populations in the United States H-350.975

It is the policy of our AMA to:
(1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community;
(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community;
(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies;
(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization;
(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics;
(6) Promote research into effectiveness of Hispanic health education methods; (7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border. CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but

not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. Res. 254, 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.
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

Support of Health Care to Legal Immigrants H-290.983

Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations. Res. 211, A-97; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12; Reaffirmed: CMS Rep. 3, I-21

AMENDING H-350.957, ADDRESSING IMMIGRANT HEALTH DISPARITIES TO INCLUDE OPPOSITION TO LEGISLATION THAT FORCES DECISIONS BETWEEN HEALTH CARE AND LAWFUL RESIDENCY STATUS 350.023MSS

H-350.957 – Addressing Immigrant and Refugee Health Disparities 1. Our American Medical Association recognized the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and

refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medical accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees, and asylees. 3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. 4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status.
MSS Res 07, I-19; Reaffirmed, MSS Res. 21, I-21

Health insurance was found to substantially reduce the out-of-pocket costs of pediatric care, with mean out-of pocket costs reduced by more than half per doctor visit, by a factor of seven for preventive-care visits, by a factor of five for sick visits, and by about half for ED visits. It Table 6 Costs at one-year follow-up for uninsured children compared with children who obtained health insurance Cost Item Mean (±SD) Cost per Child Difference P Uninsured (N = 41) Obtained Medicaid or CHIP Insurance (N = 196) ED visits $607.14 (±213) $476.92 (±400) $130.22 .09 Hospitalizations $1131.08 (±301) $730.85 (±122) $400.23 .03 ICU stays $2893.63 (±557) $934.86 (±356) $1958.77 .10 Wages and other costs related to parental missed work days $522.79 (±111) $126.20 (±30) $396.59 .04 Total costs $5154.63 (±1122) $2268.88 (±536) $2885.75 .04 Flores et al. BMC Public Health (2017) 17:553 Page 11 of 14 therefore is not surprising that compared with parents of uninsured children, parents of children obtaining coverage were about six times less likely to report needing additional income to cover the child’s medical expenses, and four times less likely to report that the child’s health caused family financial problems. 18

REPORT OF THE MEDICAL STUDENT SECTION
WOMEN IN MEDICINE COMMITTEE AND COMMITTEE ON LEGISLATION AND ADVOCACY

MSS WIM COLA Report A
(A-23)

Introduced by:	MSS Women in Medicine Committee and MSS Committee on Legislation and Advocacy
Subject:	Improving Safety of Planned Home Births through Midwifery Licensing and Regulation
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the 2022 MSS Annual meeting, MSS Resolution 19 asked the AMA to amend existing policies D-35.989 and H-245.971 to encourage appropriate selection of certified midwives for a home-birth setting. Testimony on VRC was mixed, with partial support from AAP, and opposition from AAFP. The section delegates provided comments from ACOG stating that the resolution as written would create an unnecessary scope battle. The I-22 Reference Committee recommended that MSS Resolution 19 not be adopted, on the basis of ACOG comments and a lack sufficient evidence tying lack of licensing to poorer outcomes. The Assembly extracted Resolution 19 and referred it for study.

The following resolved clauses of Resolution 19 were referred for report:

RESOLVED, Our AMA will encourage integration of community-based midwifery practice into the healthcare system to promote maternal and neonatal health and health equity by amending policy D-35.989, Midwifery Scope of Practice and Licensure, to read as follows:

> **Midwifery Scope of Practice and Licensure, D-35.989:**
> Our AMA will:
> (1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives (or its predecessor organizations) or whose education meets the International Confederation of Midwives Global Standards for Midwifery Education;
> (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards;
> (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and
> (4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.
>
> RESOLVED, Our AMA will encourage informed choice in birth setting and support legislation to improve safety of planned home birth by amending policy H-245.971, Home Deliveries, to read as follows:
>
> **Planned Home Births ~~Deliveries~~ H-245.971**
> Our AMA: (1) su~~pports the recent American College of Obstetricians and Gynecol~~ogists ~~(ACOG) statement that "the safest setting for labor, delivery, and the immediate postpartum period is in the hospital, or a birthing center within a hospital complex, that~~

~~meets standards~~ ~~jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a~~ ~~freestanding birthing center that meets the standards of the Accreditation Association for~~ ~~Ambulatory Health Care, The Joint Commission, or the American Association of Birth~~ ~~Centers"~~ informing pregnant people inquiring about planned home birth of its risks and benefits based on recent evidence; ~~and~~ (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers; and (3) supports state legislation that helps achieve favorable home birth outcomes by facilitating the appropriate selection of candidates for home birth; increasing the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education; and establishing protocols for ready access to consultation and safe and timely transport to nearby hospitals.

Your Governing Council assigned this report to the committees of Women in Medicine (WIM) and Committee on Legislation and Advocacy (COLA) with the following objective:

Should the MSS ask the AMA to amend existing policies D-35.989 and H-245.971?

In this report, we attempt to determine if the MSS should ask the AMA to amend the existing policies above by evaluating evidence on outcomes of home births, midwives, and differences in outcomes between home births and hospital births as well as licensed and non-licensed midwives.

BACKGROUND

As defined by the Midwives Alliance North America (2020), midwives are trained professionals that provide care to mothers and infants[1]. Their skills and fundamentals of practice focus on healthy pregnancies, optimal births and recovery, and provide individualized care tailored to physical, mental, emotional, spiritual, and cultural needs[1]. Core competencies as outlined by the American College of Nurse-Midwives (ACNM) (2020) and Midwifery Education Accreditation Council (MEAC) are expected of new midwives for certification through the American Midwifery Certification Board (AMBC) and are revised regularly.[2, 3] Competencies outlined by ACNM and MEAC include basic and applied science including obstetrics and neonatology, health systems and policy issues, social sciences, ethics, and clinical skills that are fundamental to providing culturally-competent healthcare that improves patient outcomes.[2,3]

Globally, the International Confederation of Midwives (ICM) creates Global Standards for Midwifery Regulation.[4] Within the United States, there is no national standard for midwifery regulation, leaving licensure and roles of midwives up to individual states.[5] Currently 36 states regulate certified professional midwives through licensure including Massachusetts, Connecticut, Pennsylvania, Ohio, West Virginia, North Carolina, Georgia, Mississippi, Iowa, Nebraska, Kansas, North Dakota, and Nevada.[6] Only one state authorizes CPM practice by statute.[6] Midwives fall within one of five categories: lay midwife, direct-entry midwife (DEM), certified professional midwives (CPM), certified nurse midwives (CNM), and certified midwives (CM). Only CPM, CNM, and CM meet ICM standards for midwifery regulation.[6, 7, 8] Services provided by midwives are dependent on their certification and licensing plus state practice restrictions, but possible services include annual gynecological exams, family planning, preconception and prenatal care, labor and delivery support, newborn care, and menopausal management.

Type of Midwife[8, 9]	Summary of Training	Certification (Y/N?)	If yes, who certifies them?	Insurance Reimbursement
Lay Midwife	Informal training through self-study or apprenticeship	N		None
Direct-Entry Midwife	Apprenticeship, self-study, midwifery school, or a college/university program	N		None
Certified Professional Midwife	Multiple educational backgrounds	Yes, in 31 states	North American Registry of Midwives	Variable coverage of private and state insurance, state dependent
Certified Midwife	Bachelor degree from an accredited institution	Yes, in Delaware, Maine, New Jersey, New York, and Rhode Islands	American College of Nurse-Midwives	Most private insurance, Medicaid coverage in New York, New Jersey, and Rhode Island
Certified Nurse-Midwife	Bachelor of Science in Nursing from an accredited institution and a Masters degree in Midwifery	Yes, in 50 states plus the District of Columbia and US territories	American College of Nurse-Midwives	Most private insurance, Medicaid coverage mandated in all states, Medicare, and TRICARE

Midwifery and Addressing Health Disparities

More and more frequently, pregnant people are choosing the option of home birth, most of which are paid out of pocket[10]. In 2018, 1 out of every 61 births in the United States occurred at home.[11] The COVID-19 pandemic seems to have further contributed, in part, to this increase, likely as a result of factors such as restricted hospital birthing policies, fear of COVID-19 exposure, or quarantine guidelines.[12] From 2019 to 2020, home births increased 21% among White pregnancies, 36% among non-Hispanic Black pregnancies, and 30% among Hispanic pregnancies. Due to this increase, as of 2021, 1.87% of White pregnancies, 0.68% of Black pregnancies, and 0.48% of Hispanic pregnancies were delivered at home.[13] Pregnant people in the United States who choose to pursue home birth options typically due so for a variety of reasons including dissatisfaction with or mistrust of healthcare surrounding the birth process, desire for control of their birth experience, patient comfort, or desire for an unmedicated birth.[14]

Insurance coverage of home births also differs. In private insurance plans, Aetna policy states "planned deliveries at home and associated services [are] not medically appropriate," and does not cover the costs associated with home birth unless mandated by the state in which an insurance enrollee resides.[15] Cigna's policy is slightly more nuanced, providing variations in coverage based on midwife licensure or certification and whether midwives are in- or out-of-network.[16] However, when examining state Medicaid programs, which traditionally provide healthcare services to low-income patients, only 21/41 responding states cover home birth costs under Medicaid plans.[17] Approximately 61% of individuals enrolled in Medicaid identify as

non-White. This may explain why a greater proportion of White pregnant people opt for at-home births.[18]

Health Outcomes of Home Births versus Hospital Births

Interest in home births has been on the rise since the 1970s. A 2020 study utilizing birth and infant death record data published by the US Center for Disease and Prevention Control found significant differences in neonatal mortality between hospital and home births. This study found the neonatal mortality for US hospital midwife-attended live births to be 3.27 per 10,000 live births compared to US home birth with certified midwife attendant neonatal mortality found to be 9.48 per 10,000 live births.[20] Grunebaum et al. (2020) utilized the national birth certificate data, which has classification bias. They collect CNM/CM versus non-CM reported data, which does not include CPM outcomes specifically.[20] Additionally, this study concluded that location of birth played a large role in the safety of the birth, while there were lesser effects from the type of attendant at the birth.[20] However, the neonatal mortality rate may not be accurate based on their classification of a home birth versus hospital birth.[20] Any home birth transfers to a hospital were classified as hospital births.[20] Homebirth transfers that had positive or negative outcomes were classified as hospital births, possibly skewing the neonatal mortality rates for both hospital births and home births.[20] There is very limited data on the three types of certified midwives compared to non-certified midwives for home birth versus hospital birth outcomes.[20]

Comparison of Health Outcomes Utilizing Midwife Care

A 2018 study examining published regulatory data from a 50-state database including key points on midwifery practice and interprofessional collaboration, scope of practice, autonomy, and restrictions found that states with higher levels of midwifery integration such as Washington had significantly higher rates of spontaneous vaginal delivery, vaginal birth after c-section, and breastfeeding.[21] Higher midwifery integration resulted in significantly lower rates of c-section delivery, preterm birth, low birth weight, and neonatal death.[21] C-sections carry additional long-term risks including risks for future fertility, pregnancies, and long-term childhood outcomes[22]. A 2018 study in Ohio, a state without midwifery licensure requirements, found pregnant people under midwifery care had lower c-section rates than those under obstetrician care, without increased odds of maternal morbidity or neonatal complication.[23] Comparatively, a 2021 study from Washington, a state that has licensure for midwifery, found a well-established and integrated midwifery practice results in lower rates of adverse outcomes and lower rates of c-sections.[24] A 2019 comparing midwifery and obstetric care in low-risk hospital births found that midwifery care decreased interventions during labor and lower rates of c-section delivery.[25] C-sections do carry their own share of risks, but it is important to note that emergent C-sections are performed as a life-saving intervention. Midwives cannot perform C-sections, which likely contributes to the decreased rate of occurrence in home-births.

Cost Effectiveness

Type of Midwife[9, 26]	Insurance Reimbursement
Lay Midwife	Not specified
Direct-Entry Midwife	Not specified
Certified Professional Midwife	Variable coverage of private and state insurance, state dependent

Certified Midwife	Most private insurance, Medicaid coverage in New York, New Jersey, and Rhode Island
Certified Nurse-Midwife	Most private insurance, Medicaid coverage mandated in all states, Medicare, and TRICARE

Insurance reimbursement depends on the level of midwifery certification as well as the individual state, but all the levels of certified midwives have some levels of insurance coverage and reimbursement for their services.[9]

A 2021 study by the Kaiser Family Foundation found that the average cost of childbirth in the US under a major insurance provider is $18,865, with out of pocket costs averaging $2,854. The study found that cesarean sections were set at an average of $26,280 with $3,200 out-of-pocket costs and vaginal deliveries costing $14,768 with $2,655 out-of-pocket costs.[27] The Congressional Research Service reported that in 2020, 91.4% of Americans were insured. Of that group, 64.9% carried private health insurance, 18.4% with Medicare coverage, 17.8% with Medicaid coverage, 3.7% with Military coverage via TRICARE or VA Care. 8.6% of Americans were reported to be uninsured.[28] According to a 2021 report, Medicaid coverage for births vary from state to state. Of the 42 states responding in the survey, 25 reported coverage for home births (midwives, doulas, or other licensed practitioners). Qualifications for coverage ranged significantly, however primarily focused on physician approval given a low-risk pregnancy situation.[29]

A standard home birth package arranged by midwives tends to include costs associated with prenatal care, delivery, and postpartum care. The average global fee for a standard package in the United States in 2020 was $4,650 with a range from $2,000 to $9,921. A survey of midwife practices revealed that for insured patients, the average global fee was $5,050 with a range from $2,000 to $16,500.[30] This likely reflected a larger range of services available as well as the insurance cap on reimbursement available in different states. The lower total cost of at-home birth is largely realized by the insurer.[31]

Insurance and Liability

The liability insurance landscape with regards to midwifery is complex and heterogeneous.[32] Midwifery is regulated at the state level. In any given state, there are different levels of certification with varying responsibilities and requirements, and each level is often administered by a different regulatory board within the state. Because of this heterogeneity, liability insurance requirements for midwives vary both between and within states. Some states, such as Alaska and Arizona, require state certification, but have no explicit requirement to carry liability insurance.[33, 34] Other states restrict midwifery to CNMs, which either carries its own specific liability insurance requirements or follows nursing requirements for that state, as in Alabama.[35]

There was concern for physician liability after patient hand-off in the event of complications during a homebirth overseen by a midwife in the state of Illinois.[36] This concern existed mostly with lay (unlicensed) midwives, and was mitigated by proper licensure requirements and legislation passed in 2021 that clarified practitioner liability at different stages of care.[36] Unfortunately, due to the diverse state-by-state regulations, questions of liability in the event of complication or malpractice remain in other states.

PREVIOUS SPECIALITY FEEDBACK

Additional concerns of the MSS Assembly related to scope of the AMA on this issue and ACOG, AAP, and AAFP feedback. AMA has current policy on midwifery scope of practice and licensure (D-35.989) and planned home birth deliveries (H-245.971). The resolved clause requested amendments to these policies that were consistent with the aims of the original policy so it would not be out of the scope of the AMA to make these

amendments. ACOG, AAP, and AAFP feedback was mixed. ACOG supported no adoption of the resolution as written on the basis of an unnecessary scope battle and lack of evidence on health outcomes and lack of licensure. AAFP also opposed the resolution based on lack of evidence on health outcomes. AAP partially supported the resolution.

DISCUSSION

Overall, there is limited research available on health outcomes of home births versus hospital births, demographic breakdown of individuals that use midwives, and explicitly comparing health outcomes with usage of the various levels of midwife licensure to non-licensed midwives.

Licensed midwives have standard education requirements, standardized protocols, and some level of insurance reimbursement, which allow for ethical standards and practice guidelines to be enforced, increasing patient safety. Expansion of licensure coverage may increase patient safety, but there is limited evidence comparing licensed to unlicensed midwives. The best data available for comparison of licensed midwives versus non-licensed midwives is state-level comparisons of states that require licensure and states that do not require licensure. However, a comparison of licensed versus non-licensed was not explicitly examined. The studies examined states with high midwifery integration states, which happened to have midwifery licensure requirements compared to low midwifery integration states, which happened to have no midwifery licensure requirements.[21, 23, 25] Generally, higher levels of midwifery integration were associated with a decreased number of c-section deliveries and adverse health outcomes including preterm birth, low birth weight, and neonatal mortality.[21, 23, 25] Resolved Clause 1 asks for an amendment to current AMA policy D-35.989 to include advocacy in legislative and regulatory arenas for licensing of midwives who are certified by the ACNM or who meet the education requirements for the ICM Global Standards for Midwifery Regulation. However, there are no current studies that show the ICM Global Standards for Midwifery Regulation has more positive healthcare outcomes in comparison to the current standards set by individual US states. When comparing the ICM Global Standards for Midwifery Regulation Essential Competencies to the ACNM's, which current AMA policy references, there are considerable overlaps in competencies for basic science and health care in obstetrics and neonatology, social sciences including trauma informed care, and clinical skills necessary in midwifery.

Some research indicates midwife licensure leads to improved integration into healthcare systems and improved birth outcomes.[21, 37] This licensure further creates protocol for midwives in the case of a poor birth outcome. Should a poor birth outcome occur, parents have no disciplinary board to report unlicensed midwives to. As with other types of medical licensure, these boards would be able to take disciplinary action such as license revocation should they deem it necessary. Without such methods for established outcome reporting, parents who experience poor outcomes with unlicensed midwives are left only with the option of formal prosecution.

In researching this topic, there was minimal evidence supporting improved outcomes for licensed vs unlicensed midwives. Additionally, ICM and ACNM guidelines are similar in competencies, and there is no peer-reviewed evidence comparing these two sets of guidelines. There is also limited evidence to remove support for ACOG's statement that hospitals are the safest setting for delivery. Considering the lack of data supporting these

significant changes to current policy your Committee on Legislation and Advocacy and Women in Medicine committee recommend that Resolution 019 not be adopted.

RECOMMENDATIONS

Your Committee on Legislation and Advocacy and Women in Medicine Committee recommend that the proposed recommendations not be adopted and the remainder of the report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
MINORITY ISSUES COMMITTEE AND COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS MIC CGPH Report A
(A-23)

Introduced by:	MSS Minority Issues Committee and MSS Committee on Global and Public Health
Subject:	Mental Health Reform in Prisons
Referred to:	MSS Reference Committee (Justin Magrath and Samantha Pavlock, Co-Chairs)

INTRODUCTION

At the June 2021 MSS Meeting, MSS Resolution 080 asked the AMA to support conducting mental health screening for individuals as they enter or re-enter the prison system in order to better provide mental health care to those in need. The J-21 Reference Committee recommended that H-430.986 be reaffirmed in lieu of the first Resolved clause of Resolution 080 and that the second Resolved clause be referred for study. The resolution was not extracted for discussion during the Assembly meeting. The AMA-MSS Committee on Global and Public Health (CGPH) and Massachusetts delegation testified in favor of adopting this resolution on the VRC whilst the Section Delegates supported referral.

MSS Resolution 080 has since been referred to the AMA-MSS Minority Issues Committee (MIC) and CGPH for a report to be completed prior to the AMA-MSS A-22 meeting. The resolve clause recommended for study was as follows:

> RESOLVED That our AMA supports conducting mental health screening of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access.

BACKGROUND

Historically, individuals with mental illnesses were institutionalized in prisons, with the prevailing goal being to minimize the trouble caused to the community by individuals with mental disorders.[1] However, in the 1700s, there was a shift towards psychiatric hospitalization with the goal to provide care to these patients.[1] Unfortunately, many of the methods used in these institutions were the rotational chair, lobotomy or long periods of solitary confinement. Deinstitutionalization as a policy for state hospitals began in the period of the civil rights movement when these practices were deemed cruel, and many groups were being incorporated into mainstream society. The belief that mental hospitals were cruel, financial reasons and the hope that new antipsychotic medications offered a cure were some of the reasons behind deinstitutionalization.[2] This led to a movement in the 1970s to close down psychiatric institutions. However, having a mental health condition was still highly stigmatized and mental health infrastructure was lacking. A multitude of such factors led to individuals with mental health needs soon finding

themselves incarcerated instead of receiving wrap-around healthcare services that supported a good quality of life.[3] While the general public may have a misconception that individuals who are incarcerated with mental health illness are violent criminals, the reality is that individuals may have been imprisoned for publicly displaying signs and symptoms of mental illness.[4] Inadvertently, it would appear, that much like the 1700s, the focus has become minimizing trouble caused to the community by individuals with mental disorders, with the carceral systems becoming yet another institution to which individuals with mental illnesses were funneled into.[5]

At present, mental health needs in the carceral system are pervasive: 20-40% of incarcerated individuals have a history of mental health illness and 30-60% have symptoms of substance use disorder (SUD) and addiction, compared to 4% of the general adult population.[6,7] This increased burden of mental health need is coupled with an increased risk of suicide and psychiatric or functional disability.[8,9] This five- to ten-fold difference in the prevalence of mental health illnesses between the community and justice-involved individuals begs the question whether current standards of mental health assessment and screening in the community are truly adequate to provide holistic mental health care and reduce recidivism.

The recidivism rate of individuals who are incarcerated is estimated to be 68% within the first three years of release from incarceration, while 83% interface with the carceral systems within nine years of release.[10] A recent study has suggested that individuals with SUD have a statistically significant higher mean rate of rearrest than those without SUD.[11] The criminalization of SUD has likely contributed to this increased rate and deterred individuals from seeking treatment for SUD.[12] On the other hand, better mental health state during incarceration and post-release have been associated with a decreased likelihood of recidivism, among other measures of post release functioning.[13]

This further suggests that the current support available in the community may not be adequate to support high quality healthcare after re-entry, and to prevent rearrest, and this a different approach might be warranted.

Subject-matter experts have been advocating for mental health screening in prisons and jails for decades. The Criminal Justice/Mental Health Consensus Project Report--released in 2002 by the Council of State Governments Justice Center, a non-partisan non-profit that receives grant funding from the U.S. Department of Justice - details the importance of mental health screening for incarcerated individuals in order to (1) prevent safety/security concerns that can jeopardize those around them, (2) prevent safety/security concerns that can jeopardize the incarcerated individuals themselves, and (3) prevent escalation of these mental health conditions to the point that they require hospitalization or result in an event which is both harmful and costly.[4] The report further underscored the role of screening in information gathering, empowering institutions to better understand the "scope of mental illness within their institutions…" and "in turn, [enhance] their ability to project the future mental health needs of their agencies and communicate to policymakers the changing needs of [incarcerated individuals]." The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, and the United States Department of Justice (DOJ) Federal Bureau of Prisons (BOP) both call for universal mental health needs assessment/screening at intake and connecting prisoners with appropriate resources both in-prison and post-release.[14] These strategies aim to create consistent and comprehensive care plans to improve mental health outcomes for the incarcerated people while they are in the justice

system as well as optimize their care upon re-entry into the community, which can lower rates of recidivism.

While many prisons screen for mental health needs in the intake process, screening remains fairly non-standardized. A systematic review of mental health screening tools used in correctional facilities yielded 22 screening tools, of which six have validated.[15] Of these, the most widely studied in the U.S. include the Brief Jail Mental Health Screen (BJMHS), Correctional Mental Health Screen for Men (CMHS-M), Correctional Mental Health Screen for Women (CMHS-W), and the Jail Screening Assessment Tool (JSAT). However, only the BJMHS has been validated in multiple large scale prison systems across different states. The BJMHS has a sensitivity of roughly 60%- 65%.[15] When replicated, the BJMHS has been shown to identify 11-30% of individuals who require further mental health assessment.[16,17] The under-screening of women and racial minorities as well as the reliability of this tool in the context of multiple admissions remain to be addressed adequately by further research.[17–19] Of note, a focus on evaluating the security risk of individuals who are incarcerated during mental health screening upon admission also prevents accurate diagnosis and adequate follow-up of mental health issues considered low risk, such as depression.

Advocates, such as the National Commission on Correctional Health Care, also identify the need for qualified mental health care professionals to administer mental health screening in prisons.[20] However, there is a lack of funding to sustain an infrastructure that might adequately screen and address these mental health needs in prisons. Correctional institutions lack a sufficient budget allocated for mental health services, leading to poor pay of mental health professionals (MHPs) for comparably high caseloads, limited funding for pharmacotherapy, and inadequate resources, like secure transport, to manage off-site treatment programs. Given the shortage of qualified MHPs, correctional officers with minimal training on mental illness are often involved in the management of mental health treatment of those incarcerated, resulting in poor recognition of mental health issues among inmates.[9] Only 40 states provide mental health training to correctional staff and only 7 of those states provide more than 4 hours of training. For comparison, a qualified mental health professional is typically an individual with education and training in psychiatry, psychology, counseling, social work, and/or nursing.

DISCUSSION

Current AMA policy, H-430.997, supports that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. However, due to the uniquely vulnerable positions of incarcerated individuals, and the significant harm to health that is incurred upon incarceration, we believe that the same standard of care will lead to inequitable outcomes due to variances in standards of living and support systems while incarcerated compared to resources available to non-incarcerated mental health patients, and in order to achieve equitable outcomes, a specialized strategy is needed.

AMA has precedence for supporting validated universal screening at entry into the correctional system. For example, H-430.987 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.

AMA policy already supports ensuring 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 (H-430.987). Meanwhile, H-430.987 recommends correctional facilities work in close collaboration with addiction treatment physician teams. Thus, we want to specifically propose support for a mental health screening tool to better facilitate the impact and intent of the prior policies. AMA Policy H-430.986 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. We suggest that including a mental health screening at re-entry will provide crucial information to connect vulnerable individuals to healthcare in the community. This is aligned with AMA's support for smooth transition.

Policy	Pertinent Components
H-430.986	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
H-60.986	ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care
D-430.997	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;
H-430.987	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 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.

Several physician groups, including the American Academy of Family Physicians (AAFP) and American Psychiatric Association, have released position statements that specifically advocate for mental health screening of individuals as they enter incarceration as a key step in identifying and therefore being able to treat mental illness at an individual level, as well as to assess the prevalence and the success of interventions at a population level.[21,22] The APA has further commissioned a Task Force for Mental Health in Jails and Prisons to address the special circumstances that surround mental health in the settings of incarceration.[23] In their reports, the APA emphasizes that screening, evaluation, and treatment for mental health issues is a cornerstone of adequate health care and that incarcerated individuals should receive access to "the same level of care" as members of the community.[22]

In 2019, the Consensus Workgroup--a collaborative effort of the American Psychological Association, APA, and National Association of Social Workers to advise the U.S. Administration and Congress on addressing health care in the criminal justice system--

released a report urging action to establish screening in local-, state-, and federal-level systems at “arrest, sentencing, and all points across the criminal justice continuum” and to “build capacity of comprehensive, community-based mental health and addiction treatment services to meet the needs of justice-involved populations and those at risk of becoming justice-involved.”[23]

Many medical institutions continuously screen for mental health via questionnaires, such as the PHQ-2, and PHQ-9 at appointments, hospital admissions, and other such touchpoints.[24] It is feasible and will likely be beneficial to extend a similar prevalence of screening in institutions for incarceration, especially at entry points, as is done in the community. Furthermore, it might be beneficial to implement such screening at the exit point of incarceration as well.

Some areas of specific consideration include:

1. A uniquely vulnerable population that would benefit from specialized care above and beyond the standard. Individuals may not feel ready to share mental health concerns immediately upon incarceration. Incarceration is a rapid adjustment and a confusing, scary time for individuals; hence, several opportunities for mental health screenings should be given. Understanding of the nuances and complexities of mental health care needs of patients who are incarcerated and living in a state with less access to care and support systems needed for adequate mental health care recovery.

   Recent data suggests that there is a high burden of health conditions amongst justice- involved individuals, with 43-51% reporting a chronic health condition, 10-17% reporting an infectious disorder, and 26-29% reporting hypertension.[25] Furthermore, one in seven people living with HIV in the U.S. re-enters the community from a correctional facility each year.[26] A study published in the Lancet has suggested that there is a strong association between jail incarceration and death rates from infectious diseases, chronic lower respiratory disease, drug use, and suicide.[27] For individuals with co-occurring mental health illnesses, SUD’s and chronic health conditions, an integrated care model is imperative to provide holistic patient-centered care.[28]

   Individuals who are incarcerated in the United States also face unique challenges while in the carceral system that further contributes to poorer mental health outcomes compared to the non-incarcerated population. Individuals who are incarcerated are kept in densely populated, often overcrowded spaces designed to restrict freedom of movement. Factors such as overcrowding, punitiveness, lack of work opportunities, and distance from social support structures are associated with higher risks of depression.[29] Restrictive housing arrangements, such as solitary confinement, also exacerbate the dehumanizing effects of imprisonment on mental health, increasing risks of mortality from suicide, homicide and opioid overdose.[30] There are also several social determinants of health that differentiate justice-involved patient populations from the general patient population. People incarcerated in prisons are over twenty times more likely to be homeless than those in the general population.[31] Tackling health disparities in patients who have been incarcerated would need to consider the different social determinants of health and their impacts. In addition, due to the disproportionate presence of trauma in justice-involved individuals, a trauma-informed primary care and

psychiatric care lens is essential to adequately serve patients who have been previously incarcerated.[32] Thus, we posit that incarcerated individuals constitute a uniquely vulnerable patient population for whom the standard of care in the community might not be sufficient.

2. Current Mental Healthcare in Carceral Settings, And Their Impact on Re-entry
   Despite court mandates and current policies, there is a significant lack of access to adequate mental health care in incarcerated settings. About 63% of people with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons.[7] Additionally, over 50% of individuals who were taking medication for mental health conditions at their time of admission did not continue to receive their medication once in prison.[33]

   Due to the disparate healthcare incarcerated individuals receive, it is imperative that upon re-entry to the community, they receive healthcare that seeks to ameliorate the lack of access during incarceration. Healthcare that is the standard of care in the community might not be sufficient to make up for the lack of access during incarceration. There is evidence that screening for mental health disorders at intake is impactful. For example, screening for mental health conditions on intake into the institution was the strongest predictor of being seen by a medical professional, which increased the rate of continuous pharmacological treatment of the mental health condition.[33] Better mental health in-prison and post-release was related to lower recidivism likelihood.[13] This shows the crucial need for the optimal kind of mental health treatment in carceral settings, and why it is critical to ensure that this is tailored towards justice-involved individuals.

3. Racial and Ethnic Inequities
   Mass incarceration has shaped racial and ethnic inequality in health in the U.S, including that of families and neighbors of those experiencing incarceration.[34] Current BOP statistics suggest that 38.3% of individuals incarcerated in federal prisons are Black, and 2.5% are Native American, whereas Census data reports that 13.4% of the U.S. population is Black/African-American and 1.3% is Native American/Alaskan Native. 30.6% of individuals incarcerated in federal prisons are of Hispanic ethnicity, while Hispanic individuals make up 18.7% of the U.S. population.[35,36]

   A recent study showed that individuals who identified as White had a 1.9 times greater odds of receiving community-based mental health and substance use treatment and a 4.5 times greater odds of receiving co-occurring disorder treatment than individuals who identified as “people of color.”[37]

4. Utilizing Re-entry
   One such interface point might be at re-entry to the community. Re-entry is the 4th intercept of the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Sequential Intercept Model (SIM), and a crucial juncture at which to connect individuals to meaningful support in the community. This SIM mapping process brings together leaders and different agencies and systems to work together to identify strategies to divert people with mental and substance use disorders away from the justice system into treatment.[14] Given the high rates of mental health conditions in the justice-involved population, and the close links between mental health and post-release outcomes, screening at the point of re-

entry to the community can identify at-risk individuals and establish linkages to appropriate treatment and diversion programs.[14]

5. Learning from Global Efforts
   Abroad, mental health screening has also been used for diversionary measures, to sort patients into facilities that are most appropriate for their mental health needs. For example, in the Netherlands, justice-involved individuals with significant mental health needs are placed in an intensive psychiatric care center with more structure and protection to prevent self-harm and harm of others.[38] The Amend program has studied the feasibility of changing correctional culture, values, beliefs and norms through implementing models from global correctional systems, such as the Norwegian system.[39] A pre–post self-assessment of the training revealed gains in knowledge and skills including in motivational interviewing, de-escalation, risk assessment, understanding incarceration's negative effects, and reducing use of solitary confinement; 40% said the experience was "life-changing."

CONCLUSION

In the United States, incarceration is often coincident with mental illness - however, incarcerated populations have significant difficulty with access to care in the prison context, and conditions within prisons often exacerbate mental illness. There are clear unmet needs in the prison context for the screening and treatment of mental illness. The asks that we propose in an alternate resolution reiterate the AMA's longstanding commitment to increasing access to health care for incarcerated populations and specific advocacy regarding screening in prisons to more effectively provide appropriate services to persons who are incarcerated.

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Global and Public Health recommend adoption of the following recommendations in lieu of the proposed Resolve clause and the remainder of this report be filed:

RESOLVED, That our AMA supports conducting mental health screening, with validated measures, of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access; and be it further

RESOLVED, That our AMA advocates for the continuation of mental health care for individuals post-incarceration and the assessment of mental health needs by screening individuals upon release; and be it further

RESOLVED, That our AMA supports continued research into other methods, including but not limited to universalized method and implementation of effective screening to identify mental health needs of incarcerated and post-incarcerated individuals.

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RELEVANT AMA AND AMA-MSS POLICY

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I 12

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

Increased Oversight of Suicide Prevention Training for Correctional Facility Staff H 430.984

1. Our AMA strongly encourages all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation.
2. Our AMA strongly encourages all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

Res. 408, 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; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21

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.
Res. 412, A-18

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;
MSS MIC CGPH Report A (A-22)
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A 00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

Health 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. 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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

MSS Delegate Report B
(A-23)

Introduced by: Ryan Englander, Section Delegate; Brittany Ikwuagwu, Section Alternate Delegate; Elora Friar, RefCom AC&B Team Lead; Anjlee Panjwani, RefCom AC&B Team Lead; Adrina Kocharian, RefCom B Team Lead; Laurie Lapp, RefCom B Team Lead; Natasha Topolski, RefCom C Team Lead; Meghna Peesapati, RefCom C Team Lead; Aliya Siddiqui, RefCom F Team Lead; Megan Quamme, RefCom F Team Lead; Sarah Mae Smith, RefCom J Team Lead; Rajadhar Reddy, RefCom J Team Lead; Kylie Rostad, RefCom K Team Lead; Heidi Ventresca, RefCom K Team Lead; Reilly Bealer, RefCom K Team Lead; Alec Calac, RefCom K Team Lead

Subject: Policy Proceedings of the Interim 2022 House of Delegates Meeting

Pursuant to our Medical Student Section IOP 9.3, the following informational report details the actions taken by your Medical Student Section Delegates, MSS Regional Delegates and Alternate Delegates, and MSS Caucus (hereby described as “MSS Delegates”) at the Annual 2022 Meeting. MSS Delegates are advised to take a position on a business item where guided by our Section’s Compendium of Actions (“internal policy”). Should no relevant internal policy exist, our Caucus may decide to vote to take a stance based on internal discussion. Those particular instances are detailed in the report below.

A series of technical errors during transmission of resolutions to the House of Delegates caused nine resolutions (“mismatched resolutions”) to be sent with incorrect language in either the whereas (Resolution 931) or resolve (Resolutions 014, 311, 815, 912, 913, 920, 930, and 935) clauses. The MSS Caucus worked with stakeholders in the House of Delegates to attempt to introduce amendments that reflected the intent of the correct language as passed by the MSS Assembly. These mismatched resolutions are specifically denoted where they occurred.

RESOLUTIONS INTRODUCED BY THE MEDICAL STUDENT SECTION

1. Res. 003 - Indigenous Data Sovereignty

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee as well as at the live Reference Committee.

HOD Action: Adopted as amended by the Reference Committee

2. Res. 004 - Supporting Intimate Partner and Sexual Violence Safe Leave

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

Table of Contents

3. **Res. 005 -** Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants

   MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee and at the live Reference Committee at I-22.

   HOD Action: This resolution was adopted as written

4. **Res. 006 -** Assessing the Humanitarian Impact of Sanctions

   MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee and worked with the original author in order to testify at the live Reference Committee at I-22, and to discuss strategy for Resolution 002 as well.

   HOD Action: Resolution 002 was adopted in lieu of Resolution 006 and adopted as amended.
   1.

5. **Res. 010 -** Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

   MSS Action: The MSS took no position on this informational report.

   HOD Action: This resolution was not considered at this meeting.

6. **Res. 012 -** Guidelines on Chaperones for Sensitive Exams

   MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee and at the live Reference Committee at I-22.

   HOD Action: Adopt as amended by HOD

7. **Res. 013 -** Hospital Bans on Trial of Labor After Cesarean

   MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee. MSS spoke with stakeholders to discuss resolution prior to deciding to withdraw.

   HOD Action: This resolution was not considered at this meeting.

8. **Res. 014 -** Gender-Neutral Language in AMA Policy (***mismatched resolution***)

   MSS Action: Because the resolution was recommended not for consideration by the Interim Resolution Committee (see below), the MSS Caucus did not speak to this item.

   HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

9. **Res. 212 -** SNAP Expansion for DACA Recipients

   MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

10. **Res. 221 -** Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

11. **Res. 225 -** Drug Policy Reform

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

12. **Res. 226 -** Support for Mental Health Courts

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

13. **Res. 229 -** Coverage and Reimbursement for Abortion Services

MSS Action: This was an immediately forwarded resolution. The Reference Committee combined this item with Resolution 231. MSS Delegates spoke in strong support of ACOG and COL's substitute resolution in the live Reference Committee.

HOD Action: Alternate Resolution 229 was adopted in lieu of Resolutions 229 and 231.

14. **Res. 230 -** Increased Health Privacy on Mobile Apps in Light of Roe v. Wade

MSS Action: This was an immediately forwarded resolution. MSS Delegates spoke in strong support of this resolution.

HOD Action: This item was adopted.

15. **Res. 231 -** Expanding Support for Access to Abortion Care

MSS Action: This was an immediately forwarded resolution. The Reference Committee combined this item with Resolution 229. MSS Delegates spoke in strong support of ACOG and COL's substitute resolution in the live Reference Committee.

HOD Action: Alternate Resolution 229 was adopted in lieu of Resolutions 229 and 231.

16. Res. 302 - Expanding Employee Leave to Include Miscarriage and Stillbirth

MSS Action: MSS Delegates testified in support of Resolution 302 on the Virtual Reference Committee and in live Reference Committee testimony where testimony was given against referral to study and stating that the Council on Medical Education amendments posted on the Virtual Reference Committee were friendly.

HOD Action: Combined amendments to H-405.960 and H-420.979 were adopted in lieu of Resolution 302, 303, and 308. Please see the annotated Reference Committee C Report for additional information.

17. Res. 303 - Expanding Employee Leave to Include Miscarriage and Stillbirth

MSS Action: MSS Delegates testified in support of Resolution 303 on the Virtual Reference Committee and in live testimony in the Reference Committee Hearing.

HOD Action: Combined amendments to H-405.960 and H-420.979 were adopted in lieu of Resolution 302, 303, and 308. Please see the annotated Reference Committee C Report for additional information.

18. Res. 311 - Supporting a Hybrid Residency and Fellowship Interview Process (***mismatched resolution***)

MSS Action: MSS Delegates worked with stakeholders in the House of Delegates to propose the corrected language as amendments on the Virtual Reference Committee. MSS Delegates supported these amendments in the VRC and in live Reference Committee testimony.

HOD Action: Alternate Resolution 311, consisting of the corrected language as proffered by the Council on Medical Education, was adopted in lieu of Resolution 311. Please see the annotated Reference Committee C report for additional information.

19. Res. 312 - Reporting of Residency Demographic Data

MSS Action: MSS Delegates testified in favor of this resolution in the Virtual Reference Committee and on the floor to extract this resolution for consideration as it was originally slated for not consideration. While amendments from the Reference Committee removed a significant portion of the resolution regarding reporting utilization of parental and family leave, MSS Delegates chose not to extract the resolution after discussions with several stakeholders.

HOD Action: Resolution 312 was adopted as amended. Please see the annotated Reference Committee C report for additional information.

20. Res. 608 - Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development

MSS Action: MSS Delegates supported the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

21. Resolution 815 – Opposition to Debt Litigation Against Patients (***mismatched resolution***)

MSS Action: MSS Delegates proposed the corrected language as amendments on the Virtual Reference Committee, and supported the amended language in live Reference Committee testimony. MSS Delegates supported the amended (corrected) language as proffered by the Reference Committee on the floor of the House of Delegates.

HOD Action: Alternate Resolution 815, which consisted of the corrected language as proffered by Reference Committee J, was not adopted by the House of Delegates after facing opposition on the floor of the House of Delegates.

22. Resolution 816 – Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin Dependent Diabetes

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee and at the live Reference Committee hearing at the Interim 2022 House of Delegates. This was an MSS-introduced resolution derived from *180.020MSS Increasing Access to Innovative Glucose Monitoring for All Diabetics*.

HOD Action: Reference Committee J recommended minor amendments that broadened the scope of the resolution to support coverage of continuous and flash glucose monitoring devices carte blanche (ostensibly for all insurers) when it is evidence-based and determined appropriate by physicians. These amendments were deemed friendly by the MSS Caucus. The resolution was not extracted and thus was adopted with Reference Committee amendments.

23. Resolution 817 – Promoting Oral Anticancer Drug Parity

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee and at the live Reference Committee hearing at the Interim 2022 House of Delegates. This was an MSS-introduced resolution derived from *55.009MSS Promoting Oral Anti-Cancer Drug Parity*. In the live Reference Committee hearing, the Young Physician Section proposed an amendment that encompassed the intent of the original resolution, written as a standalone policy rather than an amendment to existing AMA policy; MSS Delegates expressed their support for this amendment. The Council on Medical Service also proposed an amendment in lieu of the resolution, which was opposed by the MSS as nebulous and inactionable.

HOD Action: Reference Committee J recommended adoption of amendments very similar to those proffered by the Young Physician Section, which directed the AMA to

advocate for cost-sharing parity between injectable/infusable and oral therapy for cancer. These amendments were deemed friendly by the MSS Caucus. The resolution was not extracted and thus was adopted with Reference Committee amendments.

24. Resolution 822 – Monitoring of Alternative Payment Models within Traditional Medicare

MSS Action: MSS Delegates testified in support of the resolution at the live Reference Committee hearing at the Interim 2022 House of Delegates. This was an MSS-introduced resolution derived from an immediately-forwarded resolution entitled *Monitoring of Alternative Payment Models within Traditional Medicare*. The MSS extracted the resolution from the Reference Committee report, which recommended reaffirmation of existing AMA policy in lieu of the resolution, and instead made a motion for referral of the resolution for study.

HOD Action: Reference Committee J recommended reaffirmation of existing AMA policy D-160.915 Opposition to Elimination of "Incident-to" Billing for Non-Physician Practitioners, D-385.953 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk), H-373.998 Patient Information and Choice, and D-160.923 Urge AMA to Release a White Paper on ACOs in lieu of Resolution 822. The resolution was extracted by the MSS and successfully referred for study.

25. Res. 901 - Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

MSS Action: MSS Authored resolution which we testified in support of as written. Testimony in response to concerns about prison budgeting was also prepared and read aloud.

HOD Action: Referral due to mixed testimony and concern for downstream implications.

26. Res. 902 - Reducing the Burden of Incarceration on Public Health

MSS Action: MSS authored resolution that we provided positive supportive testimony for. Overall non-controversial within the Reference Committee itself.

HOD Action: Adopted as amended - amendments to both broaden and provide more specific language with actions and parameters.

27. Res. 903 - Supporting Further Study of Kratom

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

28. Res. 912 - Reevaluating the Food and Drug Administration's Citizen Petition Process (***mismatched resolution***)

MSS Action: MSS Delegates proposed the corrected language as amendments on the Virtual Reference Committee, and supported the amended (corrected) language in live Reference Committee testimony.

HOD Action: Alternate Resolution 912, consisting of the corrected language of Resolution 912, was adopted. Please see the annotated Reference Committee K report for additional information.

29. Res. 913 - Supporting and Funding Sobering Centers (***mismatched resolution***)

MSS Action: MSS Delegates proposed the corrected language as amendments on the Virtual Reference Committee, and supported the amended language in live Reference Committee testimony.

HOD Action: Resolution 913 was referred for study. Please see the annotated Reference Committee K Report for additional information.

30. Res. 916 - Non-Cervical HPV Associated Cancer Prevention

MSS Action: MSS Authored resolution which we provided positive testimony for. Controversial clause regarding mandatory HPV vaccines for school attendance and we extracted on the floor for this exact reason. We provided substantial testimony at HOD and were successful in asking for the study of mandatory HPV vaccines.

HOD Action: Amended by addition and deletion.

31. Res. 918 - Opposition to Alcohol Industry Marketing Self-Regulation

MSS Action: Limited but unanimous supportive testimony for this resolution. I believe it was MSS authored. Definitely provided positive testimony for this item.

HOD Action: Adopted.

32. Res. 919 - Decreasing Youth Access to E-cigarettes

MSS Action: MSS provided supportive testimony for the item as written. Minimal controversial points raised by Reference Committee attendees.

HOD Action: Adopted as amended by addition and deletion.

33. Res. 920 - Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (***mismatched resolution***)

MSS Action: MSS Delegates withdrew this resolution, as there was no clear path to offering corrected language via an amendment.

HOD Action: This resolution was not considered at this meeting.

34. Res. 928 - Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements

MSS Action: MSS supportive testimony. The Transplant society and Psych association both offered amendments trying to get the language correct so as not to limit transplant centers unique decision making capacity in transplant evaluation and not stigmatize mental health of addiction. Final amended language took all opinions (original language, psych, and transplant society) into account and no one extracted.

HOD Action: Adopt as amended by addition and deletion.

35. Res. 929 - Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations

MSS Action: MSS supportive testimony with counter testimony required. Quite controversial from the Correctional Physicians Section in that they did not appreciate the implication that they did not make decisions about pharmaceuticals based on clinical practice/indications/evidence and rather that they may be swayed by monetary implications.

HOD Action: Adopt as amended.

36. Res. 930 - Addressing Longitudinal Health Care Needs of Children in Foster Care (***mismatched resolution***)

MSS Action: MSS Delegates proposed the corrected language as amendments on the Virtual Reference Committee, and supported the amended (corrected) language in live Reference Committee testimony. A coalition of specialty societies led by AAP proffered additional friendly amendments on the floor of the House of Delegates with MSS input, which MSS Delegates supported.

HOD Action: Resolution 930 was adopted as amended by the Reference Committee and the American Academy of Pediatrics, which included the corrected language. Please see the annotated Reference Committee K report for additional information.

37. Res. 931 - Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs **(***mismatched resolution***)**

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 428 was adopted by the HOD. Please see the annotated Reference Committee D Report for additional information.

38. Res. 932 - Increase Employment Services Funding for People with Disabilities

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. The MSS Caucus elected not to extract it, and thus it was not considered at this meeting.

39. Res. 933 - Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

MSS Action: MSS supportive testimony. Overall supportive input from many physicians. Some input was concerned about increasing the burden of counseling on PCPs and putting too much into visits but overall very supportive.

HOD Action: Adopted as amended.

40. Res. 934 - Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

MSS Action: MSS Delegates testified in support of the resolution in the Virtual Reference Committee.

HOD Action: Recommended not for consideration by the Resolution Committee

41. Res. 935 - Government Manufacturing of Generic Drugs to Address Market Failures (***mismatched resolution***)

MSS Action: MSS Delegates proffered the corrected language as an amendment during Virtual Reference Committee testimony, and supported the corrected language during live Reference Committee testimony. MSS Delegates extracted the resolution to attempt to defeat referral, but were unsuccessful.

HOD Action: Extracted at HOD and then Resolution 935 was referred for study. Please see the annotated Reference Committee K Report for additional information.

42. Res. 936 - Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

MSS Action: Supportive testimonies overall with some concern about practicality of single use equipment.

HOD Action: Originally referred for decision, MSS extracted to have it referred for study with report back - as there were many interested stakeholders with this item. Also recommendation to reaffirm Policy H480.959.

ACTIONS ON ALL CONSIDERED REPORTS

2. BOT Report 1 – Opposition to Requirements for Gender-Based Treatments for Athletes

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: BOT Report 1 was adopted as amended and the remainder of the Report was filed.

3. BOT Report 2 – Further Action to Respond to the Gun Violence Public Health Crisis

MSS Action: The MSS testified on VRC and in RefCom F in opposition to the BOT report and in support of an amendment offered by AAP to introduce the task force again.

We also offered an additional 4 resolved clauses on VRC to add to AAP's amendment.

HOD Action: This item was not extracted, and was adopted as amended to include AAP's task force amendment and the MSS amendments.

4. BOT Report 3 – Delegate Apportionment and Pending Members

MSS Action: The MSS took no position on this report.

HOD Action: BOT Report 5 was adopted and the remainder of the Report was filed.

5. BOT Report 4 – Preserving Access to Reproductive Health Services

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: BOT Report 4 was adopted as amended and the remainder of the Report was filed.

6. BOT Report 5 – Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: BOT Report 5 was adopted and the remainder of the Report was filed.

7. BOT Report 6 (informational) – Informal Inter-Member Mentoring

MSS Action: The MSS Delegates took no position on this informational report.

HOD Action: BOT Report 6 was filed.

8. BOT Report 7 – Transparency of Resolution Fiscal Notes

MSS Action: The MSS Delegates took no position on this informational report.

HOD Action: BOT Report 7 was adopted and the remainder of the Report was filed.

9. BOT Report 8 – The Resolution Committee as a Standing Committee of the House

MSS Action: MSS Delegates strongly opposed this report in both the VRC and in Reference Committee F.

HOD Action: The recommendations of BOT Report 08 were not adopted by the House of Delegates, and the remainder of the report was filed. Please see the annotated Reference Committee F Report for additional information.

10. BOT Report 9 – Employed Physicians

MSS Action: The MSS Delegates took no position on this report.

HOD Action: BOT Report 9 was referred.

11. BOT Report 10 (informational) – Redefining the AMA's Position on ACA and Healthcare Reform

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 10 was filed.

12. BOT Report 11 (informational) – 2022 AMA Advocacy Efforts

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 11 was filed.

13. BOT Report 12 – Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: BOT Report 12 was adopted and the remainder of the Report was filed. Please see the annotated Reference Committee AC&B report for additional information.

14. Speakers' Report 1 – Election Committee - Interim Report

MSS Action: MSS Delegates took no position on this report.

HOD Action: The recommendations of Speakers' Report 1 were adopted, and the remainder of the report was filed. Please see the annotated Reference Committee F report for additional information.

15. Compensation Committee Report 1 – Report of the HOD Committee on Compensation of the Officers

MSS Action: MSS Delegates took no position on this report.

HOD Action: The report was adopted by the HOD and the remainder filed. Please see the annotated Reference Committee F report for additional information.

16. CCB Report 1 – Updated Bylaws: Delegate Apportionment and Pending Members

MSS Action: MSS Delegates took no position on this report.

HOD Action: CCB Report 1 was adopted and the remainder of the Report was filed. Please see the annotated Reference Committee AC&B report for additional information.

17. CEJA Report 1 – Amendment to Opinion 4.2.7, "Abortion"

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: CEJA Report 1 was adopted as amended and the remainder of the Report was filed.

18. CEJA Report 2 – Amendment to Opinion 10.8, "Collaborative Care"

MSS Action: MSS Delegates took no position on this report.

HOD Action: CEJA Report 2 was adopted as amended and the remainder of the Report was filed.

19. CEJA Report 3 – Pandemic Ethics and the Duty of Care

MSS Action: The MSS testified in support on the Virtual Reference Committee and the live Reference Committee hearing.

HOD Action: CEJA Report 3 was adopted and the remainder of the Report was filed.

20. CEJA Report 4 – Research Handling of De-Identified Patient Information

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CEJA Report 4 was filed.

21. CEJA Opinion 1 – Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CEJA Opinion 1 was filed.

22. CLRPD Report 1 – Senior Physicians Section Five-Year Review

MSS Action: MSS Delegates took no position on this report.

HOD Action: CLRPD Report 1 was adopted.

23. CME Report 1 – The Impact of Private Equity on Medical Training

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: CME Report 1 was adopted by the HOD. Please see the annotated Reference Committee C Report for additional information.

24. CME Report 2 – Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

MSS Action: MSS Delegates supported the recommendations of this report. MSS testified on the virtual reference committee in support of the report with amendments to include "call for the voluntary collection and public reporting of demographic data such as race, age, LGBTQ+ status, etc among medical schools and residency programs." This ask was language from resolution 312, which was originally slated for not consideration. Ultimately, the MSS extracted resolution 312 making

this amendment unnecessary. Several amendments were proposed in the reference committee hearings including the study of ERAS filters and monitoring the use and validity of novel online assessments for sampling personal characteristics for admissions selection and encouraging caution when utilizing these tools. The MSS viewed these as friendly and was in support of these amendments.

HOD Action: CME Report 2 was adopted as amended by the HOD. Please see the annotated Reference Committee C Report for additional information.

25. Council on Medical Service Report 1 – Incentives to Encourage Efficient Use of Emergency Departments

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children's Health Insurance Program (CHIP) enrollees, including frequent ED users.

2. That our AMA support state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services.

3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.

4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in Medicaid managed care monitoring and oversight, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; and intensive case management is provided to high utilizers.

5. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.

6. That our AMA rescind Policy D-130.959, which called for the development of this report.

MSS Action: On the Virtual Reference Committee, the MSS testified in support of Council on Medical Service Report 1 with an amendment by addition to strike the language from existing AMA policy *H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured* that "supports the use of 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," instead recommending substitute language that "opposes the use of co-pays and other cost-sharing measures for Medicaid patients." This language was based on MSS policy *165.024MSS Developing a Comprehensive Plan for Health System Reform* and *65.033MSS Co-payments in Prisons*, but also received a caucus vote of 79% in favor of introducing the amendment, 8% against introducing the amendment, and 13% abstaining on October 29th, 2022. This amendment received nontrivial opposition; during the live Reference Committee hearing, the MSS introduced a modified amendment that opposes the use of co-pays and other cost-sharing measures for Medicaid patients specifically receiving care in the emergency department in lieu of the offending tenth subclause in H-290.982.

HOD Action: Reference Committee J recommended adoption of Council on Medical Service Report 1 as written (without the MSS proposed amendment); the report was not extracted, and thus was adopted outright.

26. Council on Medical Service Report 2 – Corporate Practice of Medicine

MSS Action: MSS Delegates took no position on this report.

HOD Action: Council on Medical Service Report 2 was adopted with an amendment to delete "the use of mandated patient care algorithms" from the addition to AMA policy H-160.891 in the third recommendation, such that the language no longer specifies that each individual physician should have the ultimate decision for medical judgment in the domain of mandated patient care algorithms.

27. Council on Medical Service Report 3 (informational) – Health System Consolidation

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: Council on Medical Service Report 3 was filed.

28. CSAPH Report 1 – Drug Shortages: 2022 Update

MSS Action: MSS provided supportive testimony for this item.

HOD Action: CSAPH Report 1 was adopted and the rest of the report was filed.

29. CSAPH Report 2 – Climate Change and Human Health

MSS Action: MSS provided supportive testimony for this item.

HOD Action: CSAPH Report 2 was adopted as amended and the rest of the report was filed.

ACTIONS ON ALL OTHER RESOLUTIONS

1. Res. 001 – Updating Physician Job Description for Disability Insurance

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. It was not extracted, and thus was not considered at this meeting.

2. Res. 002 - Assessing the Humanitarian Impact of Sanctions

MSS Action: MSS Delegates supported this resolution proffered by the RFS, which mirrored the language of MSS-authored Resolution 006.

HOD Action: Adopted in lieu of Resolution 002 and Resolution 006

3. Res. 007 - Consent for Sexual and Reproductive Healthcare

MSS Action: MSS Delegates supported this resolution

HOD Action: Not considered by Interim Reference Committee; placed on the reaffirmation calendar

4. **Res. 008 - Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era**

MSS Action: MSS Delegates supported this resolution

HOD Action: Adoption as amended

5. **Res. 009 - Medical Decision-Making Autonomy of the Attending Physician**

MSS Action: MSS Delegates took no position on this resolution

HOD Action: This resolution was referred with report back in I-23

6. **Res. 011 - Advocating for the Informed Consent for Access to Transgender Health Care**

MSS Action: MSS Delegates supported this resolution

HOD Action: This resolution was referred.

7. **Res. 015 - Restricting Derogatory and Stigmatizing Language of ICD-10 Codes**

MSS Action: MSS Delegates supported this resolution

HOD Action: Resolution 015 adopted as amended with addition and deletion.

8. **Res. 016 - Increasing Female Representation in Oncology Clinical Trials**

MSS Action: Added late; MSS Delegates supported this resolution.

HOD Action: This resolution was adopted with addition and deletion.

9. **Res. 017 - Supervision of Non-Physician Providers by Physicians**

MSS Action: Added late; MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted as amended with changes to title.

10. **Res. 201 - Physician Reimbursement for Interpreter Services**

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted as amended.

11. **Res. 202 - Advocating for State GME Funding**

MSS Action: The MSS Delegates supported this resolution.

HOD Action: This resolution was adopted.

12. **Res. 203 - International Medical Graduate Employment**

MSS Action: The MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted as amended.

13. Res. 204 - Elimination of Seasonal Time Change

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. It was not extracted, and thus was not considered at this meeting.

14. Res. 205 - Waiver of Due Process Clauses

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted as amended.

15. Res. 206 - The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was amended and adopted. Of note, the title was changed to "Nursing Shortage."

16. Res. 207 - Preserving Physician Leadership in Patient Care

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Current policy was reaffirmed in lieu of this item.

17. Res. 208 - Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The following language was adopted in lieu of this resolution: "RESOLVED, That our AMA recognize that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. (New HOD Policy)

18. Res. 209 - Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training

MSS Action: This resolution was withdrawn from consideration.

HOD Action: No further action.

19. Res. 210 - Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time

MSS Action: MSS Delegates supported this resolution.

HOD Action: This resolution was adopted.

20. Res. 211 - Illicit Drug Use Harm Reduction Strategies

MSS Action: MSS Delegates supported this resolution.

HOD Action: This resolution was adopted, and AMA Policy H-95.989 was rescinded.

21. Res. 213 - Hazard Pay During a Disaster Emergency

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: AMA Policies D-130.970 and D-390.947 were reaffirmed in lieu of this resolution.

22. Res. 214 - Universal Good Samaritan Statute

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was referred.

23. Res. 215 - Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted as amended. Of note, one of the recommendations was a title change to “ELIMINATING PRACTICE BARRIERS FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES.”

24. Res. 216 - Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare

MSS Action: MSS Delegates supported this resolution.

HOD Action: This resolution was adopted as amended with a title change to “EXPANDING PARITY PROTECTIONS AND COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE.”

25. Res. 217 - Restrictions on the Ownership of Hospitals by Physicians

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Current policy was reaffirmed in lieu of this resolution.

26. Res. 218 - Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Current policy was reaffirmed in lieu of this resolution.

27. **Res. 219 - Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners**

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was recommended for adoption as amended and was ultimately referred for decision.

28. **Res. 220 - Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis**

MSS Action: MSS Delegates supported this resolution.

HOD Action: Current policy was reaffirmed in lieu of this resolution.

29. **Res. 222 - Allocate Opioid Funds to Train More Addiction Treatment Physicians**

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This resolution was adopted.

30. **Res. 223 - Criminalization of Pregnancy Loss as the Result of Cancer Treatment**

MSS Action: MSS Delegates supported this resolution with amendments proffered by ACOG.

HOD Action: This resolution was adopted as amended with a title change to “OPPOSITION TO CRIMINALIZATION OF AND CIVIL LIABILITY FOR PREGNANCY LOSS AS THE RESULT OF MEDICALLY NECESSARY CARE.”

31. **Res. 224 - Fertility Preservation**

MSS Action: MSS Delegates supported this resolution with amendments proffered by ACOG.

HOD Action: AMA Policy H-185.990 adopted as amended in lieu of Resolution 224 and AMA Policies D-5.999 and H-160.946 were reaffirmed.

32. **Res. 227 - Access to Methotrexate Based on Clinical Decisions**

MSS Action: MSS Delegates supported this resolution with amendments proffered by ACOG.

HOD Action: Resolution 227 was adopted as amended with a change of title to “ACCESS TO METHOTREXATE AND OTHER MEDICATIONS BASED ON CLINICAL DECISIONS.”

33. **Res. 232 - Obtaining Professional Recognition for Medical Service Professionals**

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: This item was referred.

34. Res. 233 (Late Resolution 1001) - Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project for Puerto Rico

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 233 was adopted as amended and AMA Policy D-290.975 was adopted as amended.

35. Res. 301 - Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. It was not extracted, and thus was not considered at this meeting.

36. Res. 304 - Protecting State Medical Licensing Boards from External Political Influence

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The resolution was adopted by the House of Delegates. Please see the annotated Reference Committee C Report for additional information.

37. Res. 305 - Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups

MSS Action: MSS Delegates supported this resolution and provided testimony on the virtual reference committee and in the reference committee hearing.

HOD Action: Resolution 305 was adopted as amended by the Reference Committee and House of Delegates. Notable amendments included the addition of an additional Resolve asking our AMA to consider quality of K-12 education a social determinant of health and to encourage state and local governments to make quality elementary and secondary education available to all. Please see the annotated Reference Committee C Report for additional information.

38. Res. 306 - Increased Credit for Continuing Medical Education Preparation

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 306 was adopted as amended by the Reference Committee. Please see the annotated Reference Committee C Report for additional information.

39. Res. 307 - Fair Compensation of Residents and Fellows

MSS Action: MSS Delegates supported the spirit of this resolution, however, did not have internal policy to support the prescriptive resolves (i.e. increasing resident and fellow salary by at least 50%). Given this, the MSS chose to watch this

resolution. During the live Reference Committee hearing, the MSS was asked to testify suggesting part of 310.034MSS language in lieu of the original language.

HOD Action: Policy H-310.912 and H-305.930 reaffirmed in lieu of Resolution 307. Please see the annotated Reference Committee C Report for additional information.

40. Res. 308 - Paid Family/Medical Leave in Medicine

MSS Action: The MSS supported Resolution 308 in testimony on the Virtual Reference Committee, as well as in the live Reference Committee hearing.

HOD Action: Combined amendments to H-405.960 and H-420.979 were adopted in lieu of Resolution 302, 303, and 308. Please see the annotated Reference Committee C Report for additional information.

41. Res. 309 - Bereavement Leave for Medical Students and Physicians

MSS Action: The MSS supported Resolution 309 in testimony on the Virtual Reference Committee, as well as in the live Reference Committee hearing. The support position was grounded in MSS policy *270.048MSS Expanding Employee Leave to Include Miscarriage and Stillbirth.*

HOD Action: Resolution 309 was adopted as amended. Please see the annotated Reference Committee C Report for additional information.

42. Res. 310 - Enforce AMA Principles on Continuing Board Certification

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 310 was adopted as amended. Please see the annotated Reference Committee C Report for additional information.

43. Res. 313 - Request a two-year delay in ACCME Changes to State Medical Society Recognition Program

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 313 was adopted as amended. Please see the annotated Reference Committee C Report for additional information.

44. Res. 314 - Balancing Supply and Demand for Physicians by 2030

MSS Action: MSS Delegates supported this resolution on the virtual reference committee.

HOD Action: Existing AMA policies H-200.954, H-200.955, H-200.972, H-465.988, and D-305.958 were reaffirmed in lieu of Resolution 314 via the Reaffirmation Consent Calendar. Please see the Sunday tote and Actions taken by the HOD for additional information.

45. Res. 315 - Bedside Nursing and Health Care Staff Shortages

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing AMA policy D-360.998 was reaffirmed in lieu of Resolution 315 via the Reaffirmation Consent Calendar. Please see the Sunday tote and Actions taken by the HOD for additional information.

46. Res. 316 - Recognizing Specialty Certifications for Physicians

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The House of Delegates voted to adopt the first resolve clause as amended and referred the second resolve clause to study. Please see the annotated Reference Committee C Report for additional information.

47. Res. 317 - Support for GME Training in Reproductive Services

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 317 was adopted as amended. Please see the annotated Reference Committee C Report for additional information.

48. Res. 601 - AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity

MSS Action: MSS Delegates vociferously opposed this resolution on the Virtual Reference Committee and in live Reference Committee testimony.

HOD Action: The resolution was not adopted by the House of Delegates. Please see the annotated Reference Committee F report for additional information.

49. Res. 602 - Finding Cities for Future AMA Conventions/Meetings

MSS Action: MSS Delegates supported referral of the resolution for study.

HOD Action: This resolution was referred for study by the House of Delegates.

50. Res. 603 - AMA House of Delegates Resolution Process Review

MSS Action: MSS Delegates took a preliminary position of oppose for this item, but this resolution was not considered.

HOD Action: This resolution was not considered.

51. Res. 604 - Solicitation Using the AMA Brand

MSS Action: This resolution was not considered.

HOD Action: This resolution was not considered.

52. Res. 605 - Decreasing Political Advantage Within AMA Elections

MSS Action: This resolution was not considered.

HOD Action: This resolution was not considered.

53. Res. 606 - Patient-Centered Health Equity Strategic Plan and Sustainable Funding

MSS Action: MSS Delegates opposed this resolution on the Virtual Reference Committee and in live Reference Committee testimony.

HOD Action: The resolution was not adopted by the House of Delegates. Please see the annotated Reference Committee F report for additional information.

54. Res. 607 - Accountability for Election Rules Violations

MSS Action: MSS Delegates did not take a position on this resolution.

HOD Action: This resolution was referred for study by the House of Delegates.

55. Res. 609 (Late Resolution 1002) - AMA Declares its Support for Turkish Physicians Imprisoned in Turkey in Violation of their Human and Professional Rights

MSS Action: MSS Delegates did not take a position on this resolution.

HOD Action: This resolution was referred for decision to the Board of Trustees by the House of Delegates.

56. Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

RESOLVED, That our American Medical Association support expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of marital status, gender or sexual orientation.

MSS Action: The MSS supported Resolution 801 in testimony on the Virtual Reference Committee, as well as in the live Reference Committee hearing. The support position was grounded in MSS policies *420.010MSS Infertility and Infertility Insurance Coverage*, *180.023MSS National Fertility Coverage Mandate*, and *295.239MSS Increased Education and Access to Fertility-Related Resources*.

HOD Action: Resolution 801 was adopted as amended to add service-connected disability as a patient characteristic that should not impact the expansion of reproductive health insurance coverage to all active-duty service members and veterans.

57. Resolution 802 – FAIR Health Database

MSS Action: The MSS took no position on Resolution 802.

HOD Action: Resolution 802 was adopted as heavily amended to advocate for independent non-conflicted databases of allowed amounts and charges to ensure the continued identification of provider type and the frequency by which CPT codes are used, as well as to advocate that independent databases of allowed amounts and charges be transparent on the source of their data and validate the data that they receive from payors for accuracy.

58. Resolution 803 – Patient Centered Medical Home – Administrative Burdens

MSS Action: The MSS took no position on Resolution 803.

HOD Action: Existing AMA policy *D-405.972 Physician Burnout* was reaffirmed in lieu of Resolution 803.

59. Resolution 804 – Centers for Medicare & Medicaid Innovation Projects

MSS Action: The MSS took no position on Resolution 804.

HOD Action: Reference Committee J recommended reaffirmation of existing AMA policy *D-185.950 CMMI Payment Reform Models* and *H-330.894 Demonstration Project Regarding Medicare Part D* in lieu of Resolution 804, but the resolution was ultimately extracted for discussion on the floor of the House of Delegates and referred for decision.

60. Resolution 805 – COVID Vaccine Administration Fee

MSS Action: The MSS testified in support of Resolution 805 on the Virtual Reference Committee and in the live Reference Committee hearing at the Interim 2022 House of Delegates. This support position was grounded in MSS policy *215.007MSS The Impact of COVID-19 on the Financial Viability of Various Healthcare Delivery Systems* and *440.089MSS Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities*.

HOD Action: Reference Committee J recommended the adoption of Resolution 805 verbatim; as the resolution was not extracted, it was adopted as written.

61. Resolution 806 – Healthcare Marketplace Plan Selection

MSS Action: On the Virtual Reference Committee and in the live Reference Committee hearing, the MSS testified in favor of reaffirmation of existing AMA policy *H-180.946 Sale of Health Insurance Across State Lines* in lieu of Resolution 806, with the rationale that existing AMA policy already outlines appropriate guardrails around the sale of health insurance across state lines, and supporting interstate portability of plans without any restrictions would weaken patient protections via state regulation of health insurance plans. This MSS position was established via a caucus vote in which 92% voted in favor of the position and 8% abstained on October 29th, 2022.

HOD Action: Reference Committee J recommended the adoption of a substitute resolution directing the AMA to re-evaluate and study choice and competition in the Healthcare Marketplace, especially in communities in close proximity to multiple states. The resolution was not extracted, and thus was adopted with Reference Committee language.

62. Resolution 807 – Medicare Advantage Record Requests

MSS Action: The MSS took no position on Resolution 807.

HOD Action: Existing AMA policy *H-315.987 Limiting Access to Medical Records* was reaffirmed in lieu of Resolution 807.

63. Resolution 808 – Reinstatement of Consultation Codes

MSS Action: The MSS took no position on Resolution 808.

HOD Action: Reference Committee J recommended reaffirmation of existing AMA policy *D-385.955 Consultation Codes and Private Payers* in lieu of Resolution 808, and the House of Delegates likewise reaffirmed D-385.955 in lieu of the resolution.

64. Resolution 809 – Uniformity and Enforcement of Medicare Advantage Plans and Regulations

MSS Action: The MSS testified in support of Resolution 809 on the Virtual Reference Committee and in the live Reference Committee hearing, following an MSS Caucus vote to establish a support position in which 95% of Caucus members voted in favor on October 29th, 2022. This position was developed due to significant concerns about network inadequacy, unclear benefits, hidden cost-sharing, and accountability in Medicare Advantage plans, particularly in light of multiple Department of Justice investigations for fraud.

HOD Action: Reference Committee J recommended the adoption of Resolution 809 with amendments to no longer constrain the resolution to senior physicians and incorporate components of Medicare not covered (as well as covered) in the elements that the AMA would advocate for Medicare Advantage plans to be required to post on their websites. The Reference Committee also recommended heavy amendments to the third resolve clause, instead directing the AMA to advocate that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients. The House of Delegates eventually adopted the language recommended by Reference Committee J.

65. Resolution 810 – Medicare Drug Pricing and Pharmacy Costs

MSS Action: The MSS testified in support of Resolution 810 as written on the Virtual Reference Committee and in the live Reference Committee hearing at the Interim 2022 House of Delegates. This support position was grounded in MSS policy *100.014MSS Drug Pricing Reform*, *100.029MSS Towards a Comprehensive Plan to Lower Drug Prices while Preserving Innovation*, and *105.003MSS Opposing Tax Deductions for Direct-to-Consumer Advertising*.

HOD Action: Reference Committee J recommended reaffirmation of existing AMA policies *D-330.954 Prescription Drug Prices and Medicare*, *H-110.987 Pharmaceutical Costs*, *D-110.994 Inappropriate Extension of Patent Life of Pharmaceuticals*, *H-125.978 Patient Protection from Forced Switching of Patent-Protected Drugs*, and *H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices* in lieu of Resolution 810. The resolution was not extracted, and thus existing AMA policy was reaffirmed in lieu of Resolution 810.

66. Resolution 811 – Covering Vaccinations for Seniors Through Medicare Part B

MSS Action: The MSS testified in support of Resolution 811 on the Virtual Reference Committee and in the live Reference Committee hearing at the Interim 2022 House of Delegates. This support position was grounded in MSS policy *440.051MSS A Comprehensive Education Strategy to Improve Vaccination Rates*, *250.032MSS Promoting Equity in Global Vaccine Distribution, 440.003MSS Childhood Immunization, 295.158MSS Access to Vaccinations for*

Student and Healthcare Workers, and *440.027MSS Increasing Accessibility to Meningitis Protection*.

HOD Action: The House of Delegates adopted Resolution 811 with amendments such that the AMA would advocate that Medicare (not necessarily under Part B) cover the full cost of all vaccines administered to Medicare patients at the point of care and outside of budget neutrality requirements. An amendment was also added to specify that only vaccines recommended by the Advisory Committee on Immunization Practices (not the US Preventive Services Task Force or prevailing preventive clinical health guidelines, as called for in the original resolution) would be subject to these coverage provisions.

67. Resolution 812 – Implant-Associated Anaplastic Large Cell Lymphoma

MSS Action: The MSS took no position on Resolution 812.

HOD Action: Resolution 812 was adopted with amendments to broaden the resolution to include supporting coverage for the workup for potential cancer diagnosis, staging, and locoregional treatment for all implant-associated malignancies.

68. Resolution 813 – Amending Policy on a Public Option to Maximize AMA Advocacy

MSS Action: The MSS testified in support of Resolution 813 on the Virtual Reference Committee and in the live Reference Committee hearing at the Interim 2022 House of Delegates. The support position was grounded in mirroring MSS policy *270.045MSS Amending Policy on a Public Option to Maximize AMA Advocacy*, which is identical to Resolution 813, and is also consistent with *165.024MSS Developing a Comprehensive Plan for Health System Reform*. After an unfavorable Reference Committee report, the MSS testified in support of an amendment proffered by the New England Delegation that would have directed the AMA to advocate for a pluralistic health care system **that includes** (rather than which *may include*) a public option.

HOD Action: Reference Committee J put forward an alternate resolution directing the AMA to advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. This amendment notably did not maintain the intent of the original resolution, which was to instruct the AMA to actively advocate for a public option that meets the criteria outlined in H-165.823. The New England Delegation introduced an amendment that would have restored the original intent of the resolution, stating that the AMA would advocate for a pluralistic health system that includes a public option, but this amendment failed narrowly, 46%-54%, and the language developed by Reference Committee J was adopted as written.

69. Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

MSS Action: The MSS took no position on Resolution 814.

HOD Action: Reference Committee J recommended the adoption of an alternate resolution directing the AMA to ask the United States Preventive Services Task Force to study the impact of a national coverage determination to include coronary artery calcium scoring for patients who meet the screening criteria. This language was

ultimately adopted by the House of Delegates as developed by the Reference Committee.

70. Resolution 818 – Pediatric Obesity Treatment Insurance Coverage

MSS Action: The MSS testified in support of Resolution 818 on the Virtual Reference Committee and in the live Reference Committee hearing at the Interim 2022 House of Delegates. The support position was based loosely on MSS policy *440.013MSS Obesity as a Chronic Disease*, *440.018MSS Childhood Obesity as a Public Health Epidemic*, and *170.013MSS Public School Screening for Childhood Obesity*, but also received a caucus vote of 92% in favor of supporting the resolution and 8% abstaining on October 29th, 2022.

HOD Action: Reference Committee J recommended the adoption of an alternate resolution that incorporated language directing the AMA to work with specialty societies and state associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment into existing AMA policy D-440.954, with a title change to read “Addressing Adult and Pediatric Obesity.” Resolution 818 was not extracted, and thus the alternate resolution developed by the Reference Committee was adopted.

71. Resolution 819 – Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA

MSS Action: The MSS took no position on Resolution 819.

HOD Action: Reference Committee J recommended the adoption of an alternate resolution directing the AMA to enhance physician education and awareness of the US Preventive Services Task Force guidelines to initiate preventive screening for colorectal cancer at age 45. This language was ultimately adopted by the House of Delegates as developed by the Reference Committee.

72. Resolution 820 – Third-Party Pharmacy Benefit Administrators

MSS Action: The MSS took no position on Resolution 820.

HOD Action: Reference Committee J recommended the adoption of Resolution 820 verbatim; as the resolution was not extracted, it was adopted as written.

73. Resolution 821 – PrEP is an Essential Health Benefit

MSS Action: The MSS testified in support of Resolution 821 in the live Reference Committee hearing at the Interim 2022 House of Delegates. This support position was grounded in MSS policy *20.020MSS Increase Access to HIV PrEP for At-Risk Individuals*, *20.023MSS Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV*, *20.010MSS Comprehensive HIV Programs in Correctional Facilities*, *160.022MSS Reducing Barriers to Preventive Health Care Delivery and Compensation*, and *165.019MSS Protecting Patient Access to Health Insurance and Affordable Care*.

HOD Action: Reference Committee J recommended the addition of a one-word amendment to clarify that Pre-Exposure Prophylaxis should be included as a Preventive Essential Health Benefit under the Affordable Care Act to ensure first-dollar coverage. Resolution 821 was not extracted, and thus was adopted with Reference Committee language.

74. Resolution 823 – Health Insurers and Collection of Co-pays and Deductibles

MSS Action: The MSS took no position on Resolution 823.

HOD Action: Reference Committee J recommended the referral of Resolution 823 for study; as the resolution was not extracted, it was referred for study.

75. Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets

MSS Action: The MSS took no position on Resolution 824.

HOD Action: Reference Committee J recommended the referral of Resolution 824 for study; as the resolution was not extracted, it was referred for study.

76. Resolution 825 – Minimal Sustainable Reimbursement for Community Practices

MSS Action: The MSS took no position on Resolution 825.

HOD Action: The Interim 2022 Resolution Committee recommended against consideration of Resolution 825. The resolution was not extracted, and thus was not considered at the Interim 2022 House of Delegates.

77. Resolution 826 – Leveling the Playing Field

MSS Action: The MSS took no position on Resolution 826.

HOD Action: Reference Committee J recommended the addition of a second resolve clause directing the AMA consider disseminating the educational materials and graphics called for in the first resolve clause, which are slated to illustrate the fiscal losses and inequities that practices without facility fees have endured due to the site of service differential. The House of Delegates ultimately adopted the Reference Committee language, which included the original resolve clause as well as the additional second resolve clause developed by Reference Committee J.

78. Res. 904 - Immigration Status is a Public Health Issue

MSS Action: MSS did not provide testimony - there were many implications of this policy and we did not have direct policy to support all parts of this item. Labeled as a watch.

HOD Action: Reference Committee K recommended the adoption of 904 as written. Testimony was widely supportive, and the Reference Committee noted that this resolution focused on immigration status, not the legality of immigration status. The House adopted the resolution as written.

79. Res. 905 - Minimal Age of Juvenile Justice Jurisdiction in the United States

MSS Action: MSS did not provide testimony - there was confusion over the determination of age for this item and the actual evidence to support the suggested age so we refrained from testifying.

HOD Action: Reference Committee K recommended adoption of 905 as amended. There was a discussion about an appropriate age for this item, which the Reference Committee ultimately weighed testimony to favor 14 over 10. Referral was considered, but not decided upon. The House adopted this resolution as amended.

80. Res. 906 - Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized

MSS Action: MSS provided supportive testimony .

HOD Action: Testimony was mixed. Ultimately, Reference Committee K decided that existing policy about COVID-19 vaccine mandates should be updated with explicit mention about requirements for school attendance. The House adopted this amended language in the form of a substitute resolution..

81. Res. 907 - A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury

MSS Action: MSS provided supportive testimony for this item as a show for support for the section that put this forth. There were concerns raised from our delegates about the language and focus of “illegal firearms” and some of the sources used for research in this item but they asked for support in exchange for support on another item of ours.

HOD Action: The Reference Committee heard mixed testimony about this item, with numerous concerns about the illegal firearms phrasing. Ultimately, this language was recommended to be removed. The House adopted the amended language.

82. Res. 908 - Older Adults and the 988 Suicide and Crisis Timeline

MSS Action: MSS did not provide testimony .

HOD Action: Testimony was supportive. Resolution 908 was adopted by the House as amended by the Reference Committee. The amended language focused on those groups at highest risk of suicide, as determined by appropriate stakeholders, rather than explicit mention of specific groups.

83. Res. 909 - Decreasing Gun Violence and Suicide in Seniors

MSS Action: MSS provided supportive testimony.

HOD Action: This item was adopted as amended.

84. Res. 910 - Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

MSS Action: MSS did not provide testimony for this item.

HOD Action: This item was adopted as amended.

85. Res. 911 - Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies

MSS Action: MSS provided supportive testimony at the HOD (after extraction) and Refcom.

HOD Action: This item was recommended for referral for decision.

86. Res. 914 - Greenhouse Gas Emissions from Health Care

MSS Action: No testimony - not for consideration

HOD Action: The resolution was recommended not for consideration by the Interim Resolution Committee. It was not extracted, and thus was not considered at this meeting.

87. Res. 915 - Pulse Oximetry in Patients with Pigmented Skin

MSS Action: MSS did not provide testimony

HOD Action: Adopted as amended.

88. Res. 917 - Care for Children with Obesity

MSS Action: MSS did not provide testimony on this item due to concerns about bariatric surgery in children and lack of intern policy supporting invasive measures for weight loss in children.

HOD Action: Referred for decision.

89. Res. 921 - Firearm Injury and Death Research and Prevention

MSS Action: MSS provided supportive testimony mostly as a show of support for pediatric physician section. There was some debate about the impact of this resolution from our section.

HOD Action: variety - mostly amended by addition/in lieu of but one reaffirmation

90. Res. 922 - Firearm Safety and Technology

MSS Action: Similar to 921 - supportive testimony in support of APS.

HOD Action: Current policy was reaffirmed in lieu of this resolution.

91. Res. 923 - Physician Education and Intervention to Improve Patient Firearm Safety

MSS Action: Supportive testimony on VRC - did not testify in person (though it was written) due to time constraints and overwhelming supportive testimony otherwise

HOD Action: Referral for decision and adopt as amended

92. Res. 924 - Domestic Production of Personal Protective Equipment

MSS Action: Supportive testimony provided based on our own policy.

HOD Action: adopt as amended

93. Res. 925 - Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA

MSS Action: No testimony provided/not considered - testimony written but not given

HOD Action: Current policy was reaffirmed in lieu of this resolution.

94. Res. 926 - Limit the Pornography Viewing by Minors Over the Internet

MSS Action: No testimony provided - no policy to support and questionable necessity

HOD Action: Adopted as written.

95. Res. 927 - Off-Label Policy

MSS Action: No testimony provided and no MSS stance

HOD Action: Current policy was reaffirmed in lieu of this resolution.

96. Res. 937 - Indications for Metabolic and Bariatric Surgery

MSS Action: No testimony provided and no MSS stance

HOD Action: Recommended for referral

97. Res. 938 - AMA study of efficacy of requirements for metal detection/weapons interdiction systems in health care facilities

MSS Action: No testimony provided with no MSS stance

HOD Action: Recommended for referral

Your Section Delegates wish to thank the MSS Delegates for their hard work and advocacy for the Interim 2022 policy cycle, the Team Leads for their help organizing the MSS Caucus and writing this report, and the Assembly for the excellent work it has done in creating a policy base that allows the MSS Caucus to effectively advocate for the priorities of the Medical Student Section in the House of Delegates. All of your hard work is paying dividends in moving medicine forward towards a just, equitable, and healthy future for all. Thank you for all that you do.